EVALUATION OF TRADITIONAL BIRTH ATTENDANTS (DAIS) TRAINING SCHEME IN THE STATE OF MAHARASHTRA

Sponsored by

The Ministry of Health and Family Welfare, Govt. of India

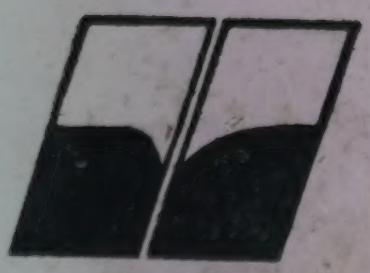
In Collaboration with the

National Institute of Health and Family Welfare, New Delhi

DR. JAGDISH C. BHATIA

Professor of Health and Population Management

Assisted by Sri N. S. Sanath Kumar, Asst. Research officer



INDIAN INSTITUTE OF MANAGEMENT

33, Langford Road, Bangalore - 560 027 INDIA

Telephone : 222394 Telegram : Management Telex : 845-472

DECEMBER 1982

02781
CPHE

CPHE

VALUATION OF TRADITIONAL BIRTH ATTENDANTS (DAIS) TRAINING SCHEME IN THE STATE OF MAHARASHTRA

Sponsored by

The Ministry of Health and Family Welfare, Govt. of India

In Collaboration with the

National Institute of Health and Family Welfare, New Delhi

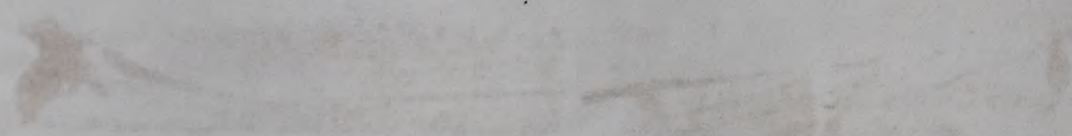
DR. JAGDISH C. BHATIA
Professor of Health and Population Management

Assisted by Sri N. S. Sanath Kumar, Asst. Research officer

INDIAN INSTITUTE OF MANAGEMENT

33, Langford Road, Bangalore - 560 027 INDIA
Telephone : 222394 Telegram : Management Telex : 845-472

DECEMBER 1982



WITH COMPLIMENTS FROM

Dr. J. C. BHATIA
Chairman (Research & Publications)
Indian Institute of Management
Bannerghatta Road,
Bangalore-560 076, India

2781
RS-130

TABLE OF CONTENTS

1. Preface

2. List of tables

3. Chapter 1 - Introduction ... 1 - 47
   (a) History of the Scheme
   (b) Review of literature
   (c) Methodology of the study

4. Chapter 2 - Dai Profile ... 48 - 65
   (a) Age
   (b) Marital status
   (c) Number of living children
   (d) Religion and caste
   (e) Education
   (f) Family vocation
   (g) Main & secondery occupation
   (h) Income
   (i) Professional experience
   (j) Period lapse after training

5. Chapter 3 - Organization of Training ...66 - 84
   (a) Designation of trainers
   (b) Marital status
   (c) Education
   (d) Experience
   (e) Selection procedures
   (f) Planning of training
   (g) Implementation of training
   (h) Observation of class room teaching

6. Chapter 4 - Efficacy of Training ... 35-122
   (a) Inputs process
   (b) Monitoring of training
   (c) Problems during training
   (d) Supervisory support
   (e) Trainees, Trainers, and organizers satisfaction with the programme

(f) Performance of dais

(g) Quality of dais' services

7. Chapter 5 - Dai in relation to community and health functionaries ...123-130

(a) Remuneration for dai's services

(b) Contact with health functionaries

(c) Payment of stipend

(d) Continuing education for dais

8. Chapter 6 - Summary and conclusions ... 131-139

9. Appendix Tables ... 140-220

10. Survey instruments ... 221-266

P R E F A C E

Inspite of tremendous advances in medical technology and considerable expansion of health services in recent times, an overwhelming majority of our population living in the rural areas is still not adequately covered with the health services net work. In terms of Alma-Ata Declaration, we are committed to provide Primary Health Care to all our population by the year 2000 AD. But to achieve this objective within the constraints of financial, physical and manpower resources is a problem of great magnitude. The task is too gigantic to be accomplished within the existing health services frame-work and new strategies and innovative approaches are patently needed. One such approach which is currently of great interest throughout the developing world is village based Primary Health Care. Under this approach, village health workers are identified and trained to provide basic preventive and curative services to the rural communities. The identification and training of Traditional Birth Attendants (TBAs) can be a very important part of this village based health care. India was the first country among the developing nations to take cognisance of the TBAs role and started training them for improving and upgrading their skills since the advent of development plans. Since 1978, the TBA training programme has received great impetus and the United Nations Fund for Population Activities (UNFPA) provided funds for TBA training schemes in the country. The UNFPA desired that the training programme be evaluated and consequently the Government of India, Ministry of Health and

.....2

Family Welfare entrusted the work relating to the evaluation of this scheme to the National Institute of Health and Family Welfare (NIHFW), New Delhi to be undertaken in collaboration with other institutions. The evaluation in the state of Maharashtra has been carried out by the Indian Institute of Management, Bangalore and the results of this evaluation are included in this report. A large volume of data was collected in this project by using six different interview and observation schedules. In a meeting of the collaborating institution held in New Delhi in September 1981, it was agreed to carry out an indepth analysis of this data by linking information from different schedules and by using rigorous statistical techniques. The computer data processing was to be done in New Delhi and the NIHFW was to provide requisite computer outputs. However, due to various constraints and limitations, the NIHFW could provide only the basic frequency distributions of data, and thus more rigorous analysis could not be possible at this end, much as we had wished to do so. We however consider this work very important and proposed to carry out further analysis, time and resources permitting, to gain further insights into the role and functioning of TBAs.

In this work many people have helped us. I am particularly grateful to the following officers of the Directorate of Health Services, Maharashtra but for whose help and cooperation, this work would not have been completed:

.....3

Dr.(Mrs.) M.R.Chandrakapure, Director, Bombay.

Dr.N.D.Palkar, Joint Director, Poona.

Dr.W.D.Muley, Assistant Director, Poona.

Dr.Lohkare, Assistant Director, Poona,

Dr.Faruquee, Deputy Director Aurangabad.

Dr.S.Khapli, District Health and Family Welfare Officer, Satara.

Dr.S.T.Kapse, D.H. & F.O. Parbhani.

Dr.B.L.Deshmukh, D.H. & F.O. Bhandara.

Dr.Sapkal, D.H. & F.O. Nagpur.

We also received valuable help and support from Dr.Ingole, Professor, Department of Preventive and Social Medicine, Government Medical College, Nagpur, for which we are grateful to him. The field interviewers travelled long distances on rugged village roads and worked long hours under difficult village roads. We fully appreciate their conscientiousness and dedication to work. The field work was supervised by Mr.N.S.Sanath Kumar and Miss.Sharada Telkar who made untiring efforts to complete the work in time and ensured the quality of data collected. Furthermore, Mr.N.S.Sanath Kumar was involved in all stages of this project. His hard work, diligence and tenacity is greatly appreciated. Mr.D.Stanley Jayaseelan provided excellent secretarial assistance for this project and beautifully typed the report at a very short notice. I highly commend his hard work and patience. Mr.Sundar Rao Mohite also helped in typing the draft and final report and

.....4

I appreciate the hard work put in by him. My sincerest thanks are also due to our Director, Prof.N.S.Ramaswamy, for his constant support and encouragement right from the beginning of this work. His commitment to rural development is well known and has been source of great inspiration in our work. It has been a great privilege and pleasure to collaborate with NIHFW in this important work and we received full cooperation from Prof.D.H.Nath and his colleagues, for which we are highly thankful. Many other people have rendered help at various stages of this project. I am fully conscious of their contributions and sincerely thank them for the same.

Dr.JAGDISH C. BHATIA

LIST OF TABLES

Sl.No.	Table No.	Title
1	2.1	Age distribution of dais in Maharastra according to location and training status
2.	2.2	Marital status of dais in Maharastra according to location and training status
3.	2.3	Number of living children of dais in Maharastra according to location and training status
4.	2.4	Distribution of dais by religionaccording to location and training status
5.	2.5	Distribution of dais by caste according to location and training status
6.	2.6	Educational status of dais according to location and training status
7.	2.7	Family vocation of dais in Maharastra according to location and training status
8.	2.8	Occupation of dais' husbands according to location and training status of dais
9.	2.9	Main occupation of dais according to location and training status
10.	2.10	Secondery occupation of dais according to location and training status
11.	2.11	Monthly family income of dais according to location and training status
12.	2.12	Total experience of dais in completed years according to location and training status
13.	2.13	Number of months lapsed after training as reported by trained dais according location.

Sl.No.	Table No.	Title
14	A 3.1	Marital status of trainers according to location
15	A 3.2	Educational status of trainers according to location
16	A 3.3	Total experience of trainers according to location
17	A 3.4	Number of batches trained as reported by trainers according to location
18	A 3.5	Total Number of dais trained as reported by trainers according to locatio
19	A 3.6	Source of information regarding training programme as reported by trained dais according to location
20	A 3.7	Source of motivation for dais to undergo training according to their location
21	A 3.8	Considerations for selecting dais for training as reported by trainers according to location
22	A 3.9	Odd beliefs and practices of dais as perceived by trainers according to location (Antenatal)
23	A 3.9a	Odd beliefs and practices of dais as perceived by trainers according to location (Intranatal)
24	A 3.9b	Odd beliefs and practices of dais as perceived by trainers according to location (Postnatal)
25	A 3.9c	Odd beliefs and practices of dais as perceived by trainers according to location (Immunization)
26	A 3.9d	Odd beliefs and practices of dais as perceived by trainers according to location (Prophylaxis against nutritional anemia)

Sl.No.	Table No.	Title
27	A 3.9e	Odd beliefs and practices of dais as perceived by trainers according to location (Family Planning)
28	A 3.10	Total number of days for classroom activities as reported by trainers according to location
29	A 3.11	Number of days for clinical activities as reported by trainers according to location
30	A 3.12	Number of days for supervised field activities as reported by trainers according to location
31	A 3.13	Number of days for unsupervised field activities as reported by trainers according to location
32	A 3.14	Number of hours per day for classroom activities as reported by trainers according to location
33	A 3.15	Number of hours per day for clinical activities as reported by trainers according to location
34	A 3.16	Number of hours per day for supervised field activities as reported by trainers according to location
35	A 3.17	Number of hours per day for unsupervised field activities as reported by trainers according to location
36	A 3.18	Topics on which lesson plans prepared as reported by trainers according to location
37	A 3.19	Teaching methods used as reported by trainers according to location
38	A 3.20	Teaching methods used in case of various Family Planning methods as reported by trainers according to location

Sl.No.	Table No.	Title
39	A 3.21	Demonstration to improve dai's practices given by trainers (Aseptic techniques)
40	A 3.22	Demonstration to improve dai's practices given by trainers (General health check up)
41	A 3.23	Demonstration to improve dai's practices given by trainers (Immunization)
42	A 3.24	Demonstration to improve dai's practices given by trainers (Management of labour
43	A 3.25	Demonstration to improve dai's practices given by trainers (Family Planning)
44	A 3.26	Training facilities available as reported by trainers according to location
45	A 3.27	Contents of evaluation of trainees as reported by trainers according to location
46	A 4.1	Major functions and activities of dai as perceived by trainers
47	A 4.2	Cooperation received from trained dais as reported by trainers according to location
48	A 4.3	Cooperation received from untrained dais as reported by trainers according to location
49	A 4.4	Shortcomings noticed in midwifery practices of dais as perceived by trainers according to location
50	A 4.5	Improvements noticed in the midwifery practices of trained dais as reported by trainers according to location
51	A 4.6	Methods employed to ensure that right skills are imparted during training as reported by trainers according to location

Sl.No.	Table No.	Title
52	A 4.7	Methods used to help slow learning dais as reported by trainers according to location
53	A 4.8	Specific guidence provided during follow-up visits to trained dais as reported by trainers according to location
54	A 4.9	Support and guidence from supervisors as reported by trainers according to location
55	A 4.10	Reasons for perceiving training as helpful, as reported by trained dais according to location
56	A 4.11	Number of cases delivered as reported by dais according to location and training status
57	A 4.12	Number of deliveries conducted independently as reported by dais according to location and training status
58	A 4.13	Number of deliveries conducted with the help of HW(F)/ANM as reported by dais according to location and training status
59	A 4.14	Number of pregnant women contacted during the past three months as reported by dais according to location and training status
60	A 4.15	Number of mothers registered at sub-centres as reported by dais according to location and training status
61	A 4.16	Number of mothers receiving atleast two doses of Tetanus Toxoid as reported by dais according to location and training status
62	A 4.17	Number of mothers receiving prophylaxis against nutritional anemia as reported by dais according to location and training status.

Sl.No.	Table No.	Title
63	A 4.18	Number of babies died as reported by dais according to location and training status
64	A 4.19	Cause of death of first case as reported by dais according to location and training status
65	A 4.20	Age at death of first case as reported by dais according to location and training status
66	A 4.21	Cause of death of second case as reported by dais according to location and training status
67	A 4.22	Age at death of second case as reported by dais according to location and training status
68	A 4.23	Advice regarding family planning as reported by dais according to location and training status
69	A 4.24	Reasons for advising family planning as reported by dais according to locati and training status
70	A 4.25	Reasons for not advising family planning as reported by dais according to location and training status
71	A 4.26	Number of persons motivated for various family planning methods as reported by dais according to location and training status
72	A 4.27	Pattern of advice given to mothers as reported by dais according to location and training status
73	A 4.28	Pattern of advice given by dais as reported by mothers according to location and training status of dais attending on them
74	A 4.29	Number of visits made by dai during pregnancy as reported by mothers according to location and training status of dais attending on them.

Sl.No.	Table No.	Title
74	A 4.29	Number of visits made by dai during pregnancy as reported by mothers according to location and training status of dais attending on them
75	A 4.30	Problems during pregnancy as reported by mothers according to location and training status of dais attending on them
76	A 4.31	Action taken by dai for swelling of feet as reported by mothers according to location and training status of dais attending on them
77	A 4.32	Number of hours of dai's presence before delivery as reported by mothers according to location and training status of dais attending on them
78	A 4.33	Accompaniment of health workers with dai at the time of delivery as reported by mothers according to location and training status of dais attending on them
79	A 4.34	Natal practices of dai during latest delivery as reported by mothers according to location and training status of dais attending on them
80	A 4.35	Natal practices of dai during previous pregnancy as reported by mothers according to location and training status of dais attending on them
81	A 4.36	Instrument used by dai for cutting the cord as reported by mothers according to location and training status of dais attending on them
82	A 4.37	Natal practices of dais
83	A 4.38	Number of hours spent by dai during delivery as reported by mothers according to location and training status of dais attending on them
84	A 4.39	Complication of mother within first fortnight of delivery as reported by mothers according to location and training status of dais attending on them.

Sl.No.	Table No.	Title
85	A 4.40	Action taken by dai for fever and PPH during latest pregnancy as reported by mothers according to location and training status of dais attending on them
86	A 4.41	Number of days of followup to mothers after delivery as reported by dais according to location and training status
87	A 4.42	Number of days of followup to newborn as reported by dais according to location and training status
88	A 4.43	Specific care provided to mothers as reported by dais according to location and training status
89	A 4.44	Specific care provided to newborn as reported by dais according to location and training status
90	A 4.45	Satisfaction with the services of dais as reported by mothers according to location and training status of dais attending on them
91	A 4.46	Reasons for satisfaction with dais services as reported by mothers according to location and training status of dais attending on them
92	A 5.1	Number of years of acquaintance with dai as reported by mothers according to location and training status of dais attending on them
93	A 5.2	Amount paid in cash to dai for her services during latest delivery as reported by mothers according to location and training status of dais attending on them
94	A 5.3	Amount paid in cash to dai for her services during previous delivery as reported by mothers according to location and training status of dais attending on them

Sl.No.	Table No.	Title
95	A 5.4	Amount paid in kind for dai's services during latest delivery as reported by mothers according to location and training status of dais attending on them
96	A 5.5	Amount paid in kind for dai's services during previous delivery as reported by mothers according to location and training status of dais attending on them
97	A 5.6	Categories of health functionaries contacted as re-ported by dais according to location and training status
98	A 5.7	Purpose of contact with health workers as reported by dais according to location and training status
99	A 5.8	Type of help rendered to health workers as reported by dais according to location and training status
100	A 5.9	Liking to work with health workers as reported by dais according to location and training status
101	A 5.10	Reasons for liking to function with health workers asreported by dais according to location and training status
102	A 5.11	Reasons for not liking to work with health workers as reported by dais according to location and training status
103	A 5.12	Time of receipt of stipend as reported by dais according to location
104	A 5.13	Remmuneration received for registering ANC cases as reported by trained dais according to location
105	A 5.14	Suggestions given by trained dais for improvement of training programme according to location
106	A 5.15	Duration of further training as reported by trained dais according to location

Sl.No.	Table No.	Title
107	A 5.16	Topics to be included in the retraining programme as suggested by trained dais according to location
108	A 5.17	Need for retraining as reported by train according to location
109	A 5.18	Time space between present training and further training as reported by trainer according to location
110	A 5.19	Place of retraining as suggested by trai ners according to location
111	A 5.20	Topics of retraining as suggested by tra ners according to location
112	A 5.21	Duration of retraining as suggested by trainers according to location
113	A 5.22	Retraining programme conducted as reporte by trainers according to location.

C H A P T E R 1

Introduction

CHAPTER I

I N T R O D U C T I O N

1.1 HISTORY OF THE SCHEME

The traditional birth attendants (TBAs) continue to provide a major part of maternal and child health (MCH) services in the rural areas of many developing countries where organised health services are not able to reach in an effective way due to a variety of reasons. Their inclusion in the health care system is therefore essential for meeting the objectives of Health for All by 2000 AD. The Government of India has realised the need for integrating the local potentials and in this connection has taken significant step of training the TBAs to improve and upgrade their practices for the delivery of efficient and effective MCH services in rural India. The main objective of the present report is to examine and evaluate the effectiveness of the working of these dais (TBAs) as well as the training programmes instituted to bring about an improvement in their functioning in the state of Maharashtra.

More than two thirds of all the births in the world are attended by untrained personnel. This is especially true in many developing countries outside of urban or peri-urban areas where the mother may deliver alone or with the assistance of relatives, neighbours or often a traditional birth

.....2

attendant[1]. Many researchers have observed in various countries, that these traditional birth attendants have contributed to high infant and maternal mortality, due to lack of asceptic measures, unclean habits and dangerous superstitions. Despite this, they have been able to muster considerable amount of social sanction in the community.

It has been estimated that there are about 0.6 million dais in India[2]. These dais continue to deliver 50-60 percent of births in rural India. Only 10-15% deliveries are accountable to primary health centres and subcentres[3]. Further, it has been corraborated by a few studies, that the available government health care utilization is suboptimal[4]. With these in view, the Government of India, with the assistance of UNFPA and other United Nations Agencies launched the program of training these traditional birth attendants as a step to integrate the local professional resources with health services

India has been the first country among the developing nations to take cognizance of this role of dais and started to train them for improved maternity practices since the advent of development plans more particularly from the II Five Year Plan. The principal aim was to help dais conduct deliveries in aseptic and hygenic manner and to bring them into linkages, with MCH services including family planning rendered through the primary health centres and subcentres. The

.....3

objectives of these training programmes are as follows:

(i) To improve the maternal and child health services in rural areas so as to reduce infant and maternal mortality by equipping the dais to handle their job in a systematic and scientific manner; and

(ii) To involve them in family planning so as to instil the concept of small family norm in the rural areas.

The Government of India initiated the scheme of training of dais during the Second Plan period (1957-62) as an MCH program, as a centrally sponsored scheme and the 100% of expenditure was borne by the Central Government. As against a target of 35,000 about 15,000 dais were trained during this period. The Scheme was continued during the Third Plan (1962-67) period and about 12,000 dais were trained as against a target of 30,000. During the Fourth Plan (1969-74) the training of dais was transferred to the family planning programmes. Though a target of training 40,000 dais was laid down, the programme received a low priority and only 16,500 dais were trained.

During the Sixth Plan (1978-83), it is envisaged to provide one trained dai for every village. The target fixed

for training is 5 million dais i.e. 1 million dais each year upto 1983. In the past, the duration of training of dais was 6 months and they were paid a stipend of Rs.2/- per day. Since the Fifth Plan, the duration of training of dais has been reduced to one month of which only 2 days per week are spent at the subcentres for instruction, demonstrations etc. and the rest of the four days in the field under active supervision of the female health workers and health assistants The stipend has been raised at Rs.300/- per month and at the end of training each trained dai is to be provided with a maternity kit free of charge. In addition she is entitled to receive a payment of Rs.2/- for every delivery conducted by her provided the case has been registered at the subcentre or PHC or MCH centre.

The task expected of her are to:

(i) get registered every pregnant woman contacted by her at the subcentre or PHC;

(ii) provide antenatal, natal, and postnatal care to mothers;

(iii) educate mothers to attend nearby subcentres for regular check up, taking tetanus toxaid and nutrition education;

(iv) ensure aseptic arrangements for home confinement;

(v) refer pregnant mothers to primary health centre in case of any complication or case beyond her competence;

(vi) educate and motivate mothers about small family and advise them about availability of family planning services at the subcentres and primary health cen tres.

(vii) educate mothers about breastfeeding, weaning immunization and spacing between children;

(viii) report vital events related to mothers and child to concerned health centre;

(ix) educate that every pregnant women takes iron and folic acid tablets as prescribed;

(x) inform mothers about the availability of MTP services;

(xi) coordinate her work with subcentre for early registration regular tests and check up of mothers and children, postnatal visits of the health workers (F) and health assistants (F) and family planning; and

(xii) seek forth replenishment of dai kit.

.....6

1.2 PROGRESS OF THE SCHEME IN MAHARASHTRA

The achievement of the target of training from the year 1977-78 to 1980-81 is given below:

Year	Target	Achievement	% of Achievement	Kits issued
1977-78	8000	3806	47.6	200
1978-79	5000	4331	86.6	2802
1979-80	7815	6284	80.4	4183
1980-81	7491	5478	73.1	10992

The districtwise achievement of these targets is shown in Table 1.1.

1.3 REVIEW OF LITERATURE

Keeping in view the significant role, the traditional birth attendants play in midwifery practices, many countries have tried in the past and are trying now to upgrade the TBAs' performance as also to integrate them into government maternal and child health programmes. Various training programmes on these lines have been organised though with varying degrees of accomplishment. A prerequisite to the success of any training programme to improve the skills and practices of TBAs is to understand their knowledge, attitudes and

TABLE 1.1

STATEMENT SHOWING THE INFORMATION REGARDING DISTRICTWISE TARGET-ACHIEVEMENT & SUPPLY OF KITS IN MAHARASHTRA

Sl. No.	District	1977-78			1978-79			1979-80			1980-81		
		Target	Achievement	Kits	Target	Achievement	Kits	Target	Achievement	Kits	Target	Achievement	Kits
1.	Raigad	333	28	-	208	160	23	340	184	160	309	193	360
2.	Ratnagiri	509	45	-	318	399	100	445	365	144	473	237	708
3.	Thane	391	234	25	244	172	170	414	336	210	364	113	240
4.	Dhule	333	234	25	208	111	240	389	322	96	309	278	520
5.	Jalgaon	372	348	25	232	194	316	363	265	80	346	349	496
6.	Nasik	372	124	-	232	175	111	282	284	230	346	197	476
7.	Ahmednagar	352	272	-	219	182	135	345	294	240	327	214	560
8.	Pune	469	327	25	293	285	270	419	326	80	436	154	804
9.	Solapur	313	48	-	196	102	56	368	100	96	291	94	280
10.	Satara	333	206	-	208	190	50	309	256	299	309	235	172
11.	Sangli	235	200	-	147	66	50	286	130	256	218	106	480
12.	Kolapur	313	192	25	196	196	130	274	274	200	291	188	432
13.	Bhandara	293	254	-	183	157	147	283	278	208	273	220	560
14.	Chandrapur	450	31	-	282	146	50	439	375	166	419	548	624
15.	Nagpur	254	117	-	159	156	123	225	204	96	236	190	368
16.	Wardha	156	124	25	98	95	110	140	157	120	145	173	312
17.	Akola	254	162	25	159	161	60	222	226	210	236	260	480
18.	Amaravati	274	263	-	172	239	72	240	240	284	255	273	544
19.	Buldhana	254	122	-	158	174	72	222	221	240	236	170	468
20.	Yavatmal	293	-	-	183	321	33	257	252	148	273	336	380
21.	Aurangabad	372	85	-	232	97	140	460	430	80	346	318	526
22.	Beed	254	27	-	159	100	32	281	206	150	236	120	120
23.	Nanded	254	114	-	159	191	68	222	159	198	236	180	362
24.	Osmanabad	293	121	-	183	122	132	318	221	96	273	144	480
25.	Parbhani	274	128	25	172	140	112	272	179	96	308	188	240

Source : Directorate of Health Services: State Family Welfare Bureau, Pune.

.....8

practices and their role in the community they serve. This is necessary in order that their potential be utilized effectively In the following paragraphs, an attempt has been made to revie the findings of some of the studies carried out to understand the attitudes, beliefs and practices of TBAs, their legal and social status in different regions of the world and the training programmes organised to improve their skills and practices.

I.3 A. TBA PROFILE

An understanding of the background characteristics of traditional birth attendants such as age, education, marital status, occupation, ethnic background, and the like, when juxtaposed with their beliefs, attitudes and practices would reveal certain interesting features which, it is hoped, would have significant policy implications for the training of traditional birth attendants.

Age is generally connected with wisdom, which comes from years of experience. In certain rural areas, the TBA who is still in the child bearing age is regarded as a novice or apprentice in midwifery. Further age has been an important indicator of TBAs' status in the community. Verderese and Turnbull[5] observe that the TBA is usually an older woman, always past menopause and must have borne one or more children herself. In Ghana[6], most of the TBAs fall into the age group

of 50-60 years. In India[7], too, they are in their late 50s. In Malaysia[8], the age of TBAs ranges between 35 and 79 and approximately 50% are over 50 years of age. Because of their age, the TBAs command considerable recognition as well as social accessibility in matters of parturition. Complementing the factor of age, is the experience of TBA. Since most of the domiciliary deliveries are attended by TBAs, it is obvious that they have gained considerable experience in their profession, regardless of their harmful or harmless practices. In a study conducted in Malaysia[9], out of the TBAs studied, 43% had practised less than 10 years, 32% had 10 to 20 years of experience and 4% had more than 30 years of experience. In Ghana, the TBAs averaged 8.5 deliveries each per year. In Bangladesh, each TBA delivered 3-4 babies per year. Verderese and Turnbull[10] observe that the percentage of estimated deliveries attended by traditional birth attendants in several developing countries varied from 60 to 80% in 1972. In Burundi, out of 143,500 estimated number of live births, 123, 238 or 85% were assisted by TBAs in 1971. In Philippines, 33.12% deliveries in 1970-72 were attended by TBAs. Further, Verderese and Turnbull, in their study of TBAs in 45 countries have found that in 39 countries, 86.7% births were attended by TBAs.

Almost all studies which inquired into TBA educational status have found them to be illiterate, thus posing a veritable bottleneck in terms of their training. However, illiteracy

.....10

has not come in the way of TBAs rapport with the community sin the communities in which they work have also very low level of literacy. With respect to marital status, most of the dais ca be classified into 'ever married' class. Croley, found in Bangladesh that most of the 'dais' were widows. Neumann and Bhatia[11] found that in Punjab, TBAs had atleast three living children. In Malaysia[12], out of the 'bidans' (TBAs) studies, 73% were currently married, 18% widowed, 8% divorced or separated and 1% never married.

Interesting findings are available so far as the source of knowledge acquired by TBAs in their profession is concerned. In Bangladesh, the TBAs' acquire their knowledge from the elders in the family who pass on their experiences to them. In Ghana, all the TBAs spend a period of apprenticeship before engaging in solo practice. Usually their mentor is a parent or grand parent. In Punjab, dais learn their profession by working with their elders. As remarked by Bhandari and Bhandar in India, dais keep the knowledge to themselves and share this only with those family members who are in their confidence. In this way, the "profession" is transferred from one generation to the other within the same family circle. Peng observes that in Malaysia, TBAs learn their profession through grand-mothers, mothers, aunts, and others. It should be mentioned here that TBAs inheritance of their profession from generations provides them with a strong base for the various activities they are engaged in. Apart from those who inherit this profession,

there are dukuns in Indonesia[14] who learn their profession by attending to births in exigencies when no other trained or professional help is available. Some also learn based on inspirations or hints from supernatural. In Ghana, it has been found that there are two types of TBAs. Herbalists who are part-time midwives and who provide only antenatal care and those who are solely engaged in midwifery and are called only after the labour has begun.

I.3 B. ROLE OF TBAs IN THE COMMUNITY

The very fact that two thirds of births in the world are attended by untrained personnel throws considerable light on the role of TBAs in the rural areas of developing countries. But, peculiar though it may seem, there are studies which show that TBAs do not hold an important role in the community. A survey conducted in West Pakistan[15] shows that the dai does not wield much influence in the community since she belongs to a lower strata of society. Another study of dais in East Pakistan (Bangladesh)[16] reveals that dais are not accorded social status since they belong to lower class. The study's findings show that very few women depend on dais and the majority depend on relatives and themselves. According to Brey[17] dais cannot be considered as influential community members since many health studies, anthropological and social surveys do not mention about these dais in their voluminous reports.

.....12

However, there are many other studies which indicate that dai does command a remarkable amount of social recognition and that proper training and utilization of her in MCH programmes would certainly benefit the people in general. In Asia, Africa and Latin American the dais are accorded, for the most part, a very high prestige in their villages. Further they have proved capable of making useful contributions to family planning communication activities in Indonesia, Malaysia, Mexico and India. In the African countries, especially Ghana, Nigeria and Tanzania the TBAs have an important role to play. This is solely due to the fact that pregnant women are attended by them (TBA) in the privacy of their own houses. In Costa Rica, she is a community leader not only in the field of health but also in various other social activities. In Cambodia, Philippines, the TBAs are reported to command high place in the social hierarchy according to the opinions expressed by various groups of people.[18]

Legally, the TBAs in most of the countries do not have any status or position accorded by the political system. In fact, in many countries, these dais are considered harmful and are banned to practice as midwives. But traditionally they have freedom to practice and are readily accepted by the community.[19] This clearly brings forth another important observation-that dais are socially accepted and recognised by the traditional social set up. As observed by Dwivedi and Rai[2]

.....13

dai inherits her profession through generations. Her profession through generations. Her profession is endorsed by the traditional social codes and norms accorded by the community at large. Hence she is provided a strong social base to operate notwithstanding her harmful customs and practices in the area of obstetrics. The dais role includes everything connected with the conduct of child birth and this is the sphere in which she holds most power and authority. Many of her beliefs and practices pertaining to the reproductive cycle are dependent upon religions and mystic sanctions. They are reinforced by rituals that are performed with traditional ceremonies which are intended to maintain the balance between the absence of ill health and the state of ill health. She adheres rigidly to the dietory rules of her community and assumes an important role in the transmission of ideas concerning the nature and effect of food. As Burgess[21] puts it, "to common problems she works out solutions within a framework of values and beliefs shared with her clients. She participates in the same social universe. At the familial level, she is more than just a useful source of physical help. She is a reassuring familiar figure, who is unhurried and patient in the assistance given to her clients, who speaks in a language and concepts they can understand and accept and who learned by experience, the proper approach to the village people. The influence of dai is also felt in other aspects of community life. She may also advise families on their health problems and difficulties; be consulted

.....14

on how to cure diseases; look after children when they are ill especially in their early years; conduct rituals when girls have their menarche; advise prspective brides on their future role; perform blessings and rituals at marriage; help the family with cooking and other domestic work; participate activ in the community work."

I.3 C. DAI AND GOVERNMENT MCH SERVICES

Many studies have mentioned the potential role of dai in modern MCH programme, in the light of her active participation in the community regarding parturition and allied aspects. How ever many constraints have been identified in utilizing the services of and mobilizing the TBAs in the government health care programmes. Some of those constraints, according to Verderese are: (a) Refusal or reluctance of TBA to alter cultural habits for fear of offending deep rooted social relation ships or religion sanctions; (b) most TBAs are elderly and illiterate. As an elder her status in the community can make her a source of opposition to new ideas and practices if she is opposed to it; (c) barriers of communication between TBA an health personnel vis-a-vis the clash of two cultures.

Many countries, including India, have tried to use TBAs in family planning programmes. In Malaysia, the Philippines and Thailand, family planning programmes utilising the assistance of TBAs are being developed on an experimental basis.

.....15

The rationale for engaging TBAs in family planning programme is that they have contact with a large number of women particularly during the post-partum period, and when these women are highly motivated to adopt family planning, it is felt that TBAs (when properly trained) can be used to promote maternal and child health and family planning in rural communities. A number of studies have been carried out to evaluate the effectiveness of various programmes which incorporated TBAs for family planning motivational work. A study carried out in West Pakistan[22] conclude that "dais is not an influential person in the community and this is a limitation of the success of the programme". This study also revealed that half of the dais in a group that was trained for FP work felt that FP would interfere with their profession. In Bangladesh[23], another study suggested that there are TBAs who can be utilized in FP programmes, but considering the relatively few deliveries each performs, it would seem that other persons who can reach the women near the time of birth should be sought. Many dais were not interested in becoming involved in family planning work. Another study conducted in Pakistan[24] indicates that dais working as FP motivator is under constant pressure by the supervisor to meet established quotas or else suffer harassment and/or job loss. Often the dai quickly loses interest and her performance dwindles rapidly. This has resulted in annual replacement rates as high as 40 per cent for the dai/family planning motivators./ The reasons, as reported by these studies, are

.....16

religious and traditional beliefs which are fundamental to the TBA and the community way of life; distance of village from clinics; advanced age of most TBAs and lack of or insufficient supervision.

I.3 D. KNOWLEDGE, ATTITUDES AND PRACTICES OF TBAs

The customs and practices of dais provide us an often grotesque but interesting picture of the methods of parturition practised. An understanding of the customs and practices of dais would go a long way in formulating and implementing programmes of utilizing as well as integrating TBAs' services into the primary health care in an appropriate manner.

I.3 E. ANTENATAL CARE

A study carried out in India[25] shows that TBAs diagnose and confirm pregnancy by looking at the women-her complexion is paler, her back wider and her breasts fuller. Most of the dais confirm and estimate the duration of pregnancy by palpating the abdomen. They count nine months forward from the LMP and add 15 days, which would be comparable to the usual estimation. In matters of dietary advice to pregnant women, the TBAs instruct what the pregnant women should "do or eat"; "not to do or eat". As a rule, advice on what the pregnant women "should not do or eat" outweighs prescription of what she should "do or eat". Verderese[26] observes that in Ghana

.....17

during pregnancy talismans and charms are worn and special herbal potions are taken at fixed times to get rid of all evil influences. In another study of attitudes and practices of TBAs[27] in Ghana, two types of TBAs were found. The first type were purely herbalists who provided only antenatal care and attended to complications of pregnancy and delivery. The second type of TBAs were engaged in solely midwifery and were usually called only after the labour had begun. In Nigeria[28] only a few antenatal problems were looked into, e.g. puffiness and oedima are regarded as ominous signs for which herbs with diuretic action are given. Eclampsia is treated by rubbing ground bark of trees on the body. Complications are attributed to promiscuous behaviour either before or during the pregnancy in question.

I.3 F. MANAGEMENT OF LABOUR

Practices of TBAs while attending at the time of deliveries differ from region to region. In India[29] sometimes a child birth closely resembles a criminal scene. The mother is forced to assume awkward postures and all kinds of dramatic motions are performed on her abdomen. Ventilation in the place of delivery is strictly prohibited lest God of death should enter the room. The room is made smoky to avoid evil spirits. When the labor begins[30], the vaginal canal is lubricated with clarified butter or the common mustard oil. This is repeated with manual stretching of the birth canal. Usually warm milk with

.....18

butter is given to mother. In Ethiopia[31], during delivery butter is applied to the abdomen and the abdomen is massaged to stimulate contraction of the uterus. In order to reduce the suffering of women during delivery, a red hen is tied to the bed. In Phillipines[32], raw eggs are given to the mother as labour starts with the belief that it will provide grease to the birth canal and the child will "just slide" smoothly. When labour becomes exceedingly difficult, pots, bamboo tubes, glasses and so forth are uncovered by removing the lids. In Rural Malaysia[33] prolonged labour is attended to by forcible expulsion of placenta through external pressure. In complications, the m edicine man is called to recite incantations instead of sending the mother to hospital. Delivery of women is often done with certain traditional procedures aimed at speeding the expulsion of the baby, quick passage of the placenta and arrest of hamorrhage. These practices may range fro application of heat on the abdomen of the women, to making her run up and down steps or maintaining certain position, externa pushing on the uterus, internal version by using the hands, packing of birth canal to arrest post-partum haemmorhage.

I.3 G. POST NATAL CARE AND CARE OF NEW BORN

After the child is born, the cord is cut with an instrument which may vary from one TBA or area to another and may be used for many other purposes such as razor blades, scissors, kitchen knives, sickles bark of bamboo, sharp stones or any

.....19

other available sharp object. Hygienic precautions are not always observed. In Nigeria[34], while conducting the delivery, the TBA keeps stretching the perieum scratching it with nails. The perinial tear is not repaired as it is believed that this will make future deliveries easier and quicker. To prevent pastpartum haemmorhage, very cold water is thrown over the women to keep her awake and to stop the bleeding. In the state of Punjab, India[35], the placenta is disposed in a peculiar manner. It is wrapped up in a piece of cloth, with a handful of grain, jaggery and salt and burried one to two feet deep, in a corner of the main room in the house.

In Philippines after the child is born, a prepared bitter juice of AMPALAYA (MOMORDICA CHARANTIA LINN) mixed with honey is given to the child. This is to cause him to vomit "whatever he has sucked from mother's blood while inside the womb". In Indonesia, the care of mother and infant is generally continued for 40 days after child birth. Post natal care consists of massage, dispensation of medicinal herbs, advice on recommended and forbidden foods, acts and rituals[36]. In India[37], dais blow on the urethral meatus if a baby does not pass water. They give "gutti" to a baby who does not pass stool. Eye infection of children is treated with 'kajal' with warm ghee and with 'Ian' which is made from putting a dish over a mustard oil lamp. Lack of breast milk is attributed to "shadow"

.....20

falling on the women. Reflection of light is believed to cause tetanus. TBAs' attitude towards family planning, and spacing of children is very interesting. In a study done in Africa[38] 95% of the TBAs interviewed supported spacing of children for the health of mother and child. 83% were aware of family planning methods and 70 per cent approved of it. Pakistani[39] dais had knowledge of limiting family size, but more than 60% of them were not aware of FP methods. Many of these dais felt that FP would affect their profession.

I.3 H. TRAINING OF TBAs - IMPLICATIONS

During the past decades, modern midwifery has been gradually introduced in the rural areas of many developing countries. A number of training programmes have been organised under which many TBAs have been provided with varying amount of training in simple hygiene, sterile techniques, elements of modern midwifery and family planning. Most of these training programmes have been and are being conducted with the help of the WHO and UNICEF for improving the skills of TBAs. A summary of major training programmes is given in the following table:

.....21

SUMMARY OF TRAINING PROGRAMS FOR TBAs IN SELECTED COUNTRIES

Country	Major Training Programs	Use in FP Programs
GHANA	Danfa Comprehensive Rural Health and Family Planning Project has registered 237 TBAs in research area. Started detailed interviewing and pilot training program to improve midwifery care.	
INDIA	Various states have reported registration and training programs of dais.	Used in some regions
INDONESIA	By 1965 an estimated 29,000 TBAs were trained in conjunction with UNICEF and local government MCH Centres.	Government initiated training course of dukuns in FP as part of MCH program. Preliminary Reports indicate that dukuns are contributing to FP referral rates.
MALAYSIA	(1962-63) general midwifery training given to small number of bidans.	1969-71 National Family Planning Board and UNICEF conducted FP training programs for 772 bidans. 1972, pilot project begun.

.....22

Country	Major Training Programs	Use in FP Programs
WEST PAKISTAN	On the job training given by Public Health Schools in urban areas district hospitals and MCH centres provide training for dais in rural areas.	Part time field work in family planning, receive salary and commission, under quota system.
PHILIPPINES	(1954-72) 8,866 hilots trained in program sponsored by government and UNICEF. Upon completion ofcourse, trainee given midwifery kit.	1971, one week cours given to 140 hilots. 44 selected for work as Family Planning referral agents.
THAILAND	(1967) UNICEF sponsored training of 800 TBAs. Estimated number trained over 17-18 year span of on-going training:18,000.	Approximately 16,000 trained by governmen in pilot project, us to recruit family pl ing acceptors.

SOURCE: Neumann, P.K., Ampofo, D.A., Nicholas, D.D., Ofosu-Amaa Wurapa, F.K., : Traditional Birth Attendants - A Key to Rural Maternal and Child Health and Family Planning Ser ces. ENVIRONMENTAL CHILD HEALTH, February, 1974.

.....23

India, probably was the first country to utilize TBAs in a National FP programme starting in early 1960s. UNICEF sponsored project of training dais began in 1957. The number of dais covered in training programme was 75,000 by 1971. The Government of India initiated the scheme of training of dais during II Five Year Plan (1957-62). About 15,000 dais were trained during this period. Between 1961-67, about 12,000 dais were further trained. During the fourth plan period (1969-74), the program was transferred to family planning programme, and due to low priority received by the training program of dais, only 16,500 dais were trained as against a target of 40,000. In the sixth plan (1978-83), it is envisaged to provide one trained dai for every village. The duration of the training is 1 month. The stipend received by each trainee is Rs.300 and at the end of training, the trainee receives a midwifery kit free. In addition, she is entitled to receive a payment of Rs.2 for every delivery conducted by her provided the case has been registered at the sub-centre or PHC or MCH centre. In the experiments carried out by the Narangwal[40] projects, dais were encouraged to conduct normal deliveries, but were advised to refer women for antenatal and post-natal care to specially trained family health workers. They were paid Re.1 for reporting each ANC or PNC mother to the clinic. They were also advised to seek the help of trained workers in case of complicated or prolonged labour. However, these programmes of training dais have had limited success due to a

.....24

variety of reasons. Dwivedi and Rai[41] observe that the failur of dai training was due to the non acceptance of programme and aseptic delivery by community and dais respectively. They further observe that: (i) the emphasis was placed on training of dais and not on their education; (ii) no effort was made to prepare the community for the programme. Roger and Solomon[42] consider the short duration of the training programme and low status of dais as the main causes of failure of the dai training programme in India. According to Brey[43], the reasons of failure are (a) the plan failed at practice (b) allowances were not paid properly (c) midwifery kits were often not suppl (d) there was no continued inducement to the dais to keep in touch with the MCH personnel after training. Furthermore, th social context in which dai functions does not encourage radical changes and hence she is compelled to look for a governmen post.

The revised program of 1967 attempted to correct these anomalies by (i) intensification of programme with PHC as base (ii) stipend of Re.1 per day on attendants and an expenditure of Rs.30 per dai (iii) kit to each dai after training (iv) registration of trained dai at PHC. Despite these measures, the training programme failed due to the following reasons (i) the retainer fee was rejected since dai considered that this was a life time employment (ii) Rs.20 for replenishment of kit was insufficient (iii) in southern parts

.....25

of the country, no identifiable group existed to be trained (iv) some states simply refused the scheme for reasons not very clear. Brey further, emphasise the need for accurate statistics to assess the extent and acceptance of dais role in delivery and other services. He recommended that dai training should be linked with the MCH programmes. Neumann and Bhatia[44], in a study carried out in Punjab point out that lack of supervision can result in trained TBAs returning to unsound practices. The results of their study showed that in a group of sixteen dais, ten had undergone training and had received a certificate in the government training programme, but all sixteen reported procedures in midwifery which were harmful. Midwifery kits were not maintained properly and were not used. Mani[45], in his study of administrative and communication problems in dai training in Tamil Nadu, points out following reasons (a) improper, slow and inadequate communication of procedures followed from headquarters to PHCs; (b) non-consideration of local conditions needs and availability while selecting PHCs for TBA training; (c) inadequate consultation with the PHC staff selected for administering the training programme; (d) inadequate supply of teaching aids equipments and midwifery kits; (e) non-supply of syllabus to PHC staff regarding the purpose and objectives of TBA programme; (g) lack of uniform procedures in the selection and screening of TBAs for training; (h) total absence of community involvement. Mani[46]

.....26

in another study of review of TBA program points out that dai training programmes appeared to be supply based rather than demand based - no effort is being made to educate the rural communities about the value of the midwife training programme In other words, preparation of the communities to accept, or even to demand, the services of trained midwives is as important as the training programme itself.

In Pakistan during the period 1965-70, 37,000 dais were used as the frontline field staff for family planning work, but were replaced later by full time workers. 50,000 dais were recruited as lady organizors and were trained for a week Each dai covered 2 villages or a population of 2000 in urban areas. Their responsibilities included (i) family planning motivation (ii) supply of contraceptives; (ii) follow up cases and collect other required statistics documented by superior agencies; (iv) refer IUD cases and eventually getting trained to do IUD. On an average, a dai recruited 1.3 IUD acceptors per month. As communicators of FP message dais have produced highly commendable results according to Ahmed[47]. As against the target of 50,000 dais, there were almost 36,500 active in the field as of July 1, 1970. A study by the West Pakistan Research and Evaluation Centre shows that the sharp decline in output of dai observed after her first six to nine months reported both for East and West Pakistan and with respect to the "effective" and "ineffective" dais is presumably explained

.....27

by the inability of an average midwife to move out of the narrow circle of families with whom she has long standing professional links. Another study in West Pakistan indicates that exposure of the dais, through lectures and demonstration by experts, to the need for family planning had a significant eff ect on their motivations to work as family planning workers.[48]

The Dutch colonial government in Indonesia utilized 'dukuns' (TBAs) for MCH activities in the 1930s. Traditional birth attendants training programme with the assistance of UNICEF was taken up in Indonesia in the year 1952 and by 1974, 36,000 TBAs were trained. Since TBAs occupy an important role in the community and can constitute available potential for assisting FP program, a national conference on 'Dukuns' and FP was held in 1972 and a policy decision was taken to train them as family planning field staff. The objectives of this training were to increase awareness of the importance of family planning; to obtain the cooperation and participation of dukuns; and to iss ue clear instructions. Mugue[49] has observed that the Indonesian Family Planning Programme has met with remarkable success, considering the social and cultural obstacles facing it, with the cooperation of TBAs, MCH clinics, and specially trained family planning workers. Studies show that dukuns considered training as valuable for the accumulation of know-ledge which in turn adds to their prestige. Ryder and Djuamarini[50], have suggested certain steps to make the training

.....28

of dukuns more effective and also emphasise the need for follow-up and continuous supervision of the activities of dukuns. Their recommendations include: (i) utilization of audio-visual aids; (ii) provision of incentives and transportation money (iii) use of language easily understandable to dukuns; and (iv) selection of trainers with substantial experience. They further recommend refresher courses every month beginning six months after the basic training course, consisting of discussions, problem solving etc. There are al studies[51] which show that many dukuns in Indonesia did not react favourably to the new methods of midwifery taught durin the training and considered the procedure inherited as superi Furthermore, many dukuns were not able to attend the training programmes due to domestic problems, difficulty in taking tim off from their other occupation, and physical inaccessability of the clinics where the training programmes were conducted.

In Malaysia[52], a UNICEF assisted three week training pro gramme in MCH and FP began in 1960 and by 1974 about 700 "Kampun bidare" (TBAs) had completed this training course. Out of these, 104 were given a fourth week training and were recruited as salaried employees to motivate women to adopt family planning and resupply them with pills. In 1970, a sy tematic attempt was made to develop complementary roles for the institutionally trained midwives and traditional birth

attendants. Trained midwives were asked to concentrate on the actual delivery of the mother, cutting of cord, and care of the new born, while the TBAs were encouraged to restrict themselves to other traditional duties, to support breast-feeding and motivate the mothers for family planning. As a result of this new strategy, the proportion of domiciliary deliveries attended by each type of midwife underwent a reversal and by 1972-75, proportion of domiciliary deliveries attended by institutionally trained midwives almost doubled (34.8% in 1966-70 to 62.4% in 1972-73).

In Philippines[53], until around the early 1950s the government's general attitude had been to discourage 'hilot' (TBA) practice. In 1951, the Department of Health found that 75% of the deliveries were conducted by TBAs. Infant mortality in the rural areas was also found to be quite high and the available trained medical manpower grossly inadequate to overcome the problem of medical manpower shortages and to bring down the infant mortality rate it was decided to provide necessary training to the TBAs in hygienic procedures of conducting a normal and safe delivery. In 1954 with the assistance of WHO and UNICEF, the Department of Health initiated the training of hilots and biweekly classes were held for twelve weeks and each class lasted for three hours. By 1974, 8,900 TBAs were trained. A family planning pilot project for hilots began in 1971 in Mariaduque province by the Institute of Maternal and Child Health and a total of 500 hilots were trained in family planning by 1975.

.....30

In Thailand[54], over 18,000 'mob aam yae' (TBAs) have be trained in MCH activities. 145 traditional midwives were involved in a field experiment conducted by the Department o Maternal and Child Health Mahidol University, in which train and incentives were given to TBAs for recruiting family plann ing adopters.

In Iran[55], the TBAs receive six months training before they are allowed to practice. In Iraq[56], the training progra for TBAs include two weeks theory and two weeks clinical mid- wifery training, and each TBA is provided with a UNICEF kit.

The programmes for the training of TBAs have also been initiated in many African countries. In Ghana[57] the DANFA Comprehensive Rural Health Project undertook a programme to enlist and train TBAs with a view to: (i) motivate and train TBAs to monitor women during antepartum period; (ii) motivate and train the TBAs to recognize and refer high risk women or serious complications of pregnancy or delivery; (iii) train the TBA to perform safer deliveries. In Nigeria, the trainin of TBAs began in 1966, first in the area of Abaradi and then gradually extended to other areas. The programme consists of giving the TBAs some elementary medical training to enable th to intervene before, during and after delivery. The course lasts for 10-15 days under the direction of a trained midwife or a nurse and with the assistance of women's extension orga- nisations. Those who complete the training successfully are

.....3

provided with a record book for entering every birth assisted by them and a midwifery kit. In Liberia, TBAs are trained in 12 sessions. The trainees receive a UNICEF stipend and a delivery kit. In Senegal, TBAs are given on-the-spot training utilizing simple techniques and equipments and are also taken to maternity hospitals for additional training or practical experience. In Tanzania, one TBA from each village is trained for three months after which she is provided with necessary equipment. In Togas, TBAs receive refresher courses from time to time at the district hospital. In Libya, only a few TBAs have been trained by qualified midwives since 1968. These TBAs perform regular home deliveries and have regular contact with the health centres. In Moracco, some knowledge of hygiene and health education is given to the Kablas (TBAs) during home visits. In Egypt, a programme to train TBAs was initiated in the year 1954 which envisaged to train each TBA every four years under the supervisior of MCH physicians. This programme was, however, suspended in the year 1960 with a view to replace TBAs by institutionally trained midwives and assistant midwives.[58]

The above review shows that TBAs are not an homogenous group and their role, practice, beliefs and characteristics differ from region to region or even from village to village. They play an important role in maternal and child care in the rural areas of developing countries. Many of their practices

.....32

are harmless and provide psychological and emotional support to the mother and the family. However, there are certain practices which are harmful to the mother and child and need to be eradicated. They generally do a good j ob in case of normal delivery but are not able to do anything when complication arises. Many training programmes which have been organised in various parts of the world to improve their skil and practices have not been very successful. Many training programmes which have been organised in various parts of the world to improve their skills and practices have not been ver successful. Many TBAs who have received training about the concept of modern midwifery have failed to utilise their know ledge and continue to practice procedures and methods which they have inherited. This is probably because they are not yet convinced about the modern techniques. The reasons for the failure of many of these training programmes as reported by many studies are lack oi sufficient knowledge about their activities, influence and social status.

I.4. METHODOLOGY OF THE STUDY

From 1st April 1978, the UNFPA has provided funds for the Dai training scheme in the country. The UNFPA desired that the training programme be evaluated and consequently, the Government of India entrusted the work relating to evalu tion of this scheme to NIHFW, New Delhi, to be undertaken in collaboration with other institutions.

.....33

I.4 A. OBJECTIVES

The aim is to evaluate the quality of dais' training, their present functioning, changes in their practices, collaboration, and coordination with the health functionaries and community perception of services rendered by them.

Furthermore, the study will also assess the performance of health workers (F)/ANM in relation to training and technical guidance provided to dais.

I.4 B. SPECIFIC OBJECTIVES

(1) To study the profile of trained/untrained dais in terms of:

(a) Socio-cultural, educational status and income.

(b) Professional apprenticeship and experience as dai.

(c) Motivation for training.

(d) Interpersonal relationship with other dais, health functionaries and community; and

(e) Own performanc e perception regarding last 5 cases in relation to:

(i) cases registered and care provided at various stages;

(ii) deliveries conducted - independently
- with HW (P)/ANM/Others

(iii) referrals.

(iv) FP motivational activities.

.....34

(2) To assess the training of dais including their training performance in terms of

(a) enrolment;

(b) duration;

(c) facilities at the training centre;

(d) curricular inputs-mix between theory and practice;

(e) field training organization-deliveries to be conducted:

(i) supervised; and

(ii) unsupervised.

(f) competency based objectives - dai's role and responsibilities;

(g) trainer capability and motivation;

(h) teaching methods and aids being used;

(i) interpersonal interactions between students/ trainers in the class and field with emphasis on handling of responses and procedures of reinforcement of learning;

(j) level of communication (vocabulary, terminology and languages used);

(k) evaluation procedures (testing methods and feed back to students);

.....35

(l) need for continuing education (retraining) as perceived by dai and trainer;

(m) use of reference/teaching material;

(n) management of training inputs and logistics, honorarium, stipend, kit etc.,

(o) any system of accredition or recognition.

3. To assess the job performance of dais, and that of trainer in relation to training and guidance provided on the basis of last 5 cases recalled by dai.

(a) range of service rendered (based on range of services expected according to the tasks for which trained;

(b) quantity of care in terms of improved maternity practices rendered;

(c) use of appropriate equipment (maternity kit, medicines);

(d) appropriate referrals, consultations and FP/motivation and information regarding MTP;

(e) problem solving during emergent situations.

In addition to above, the following aspects are further assessed from the trainer (HA (F)/LHV or HW (F)/ANM.

4. To study the perception of community about dais and their services.

5. To study the implementational problems of dai training a

   A. (i) district;(ii) PHC levels.

   B. The level of trainer.

I.4 C. AREA OF THE STUDY

The evaluation of the dais training being an All India study, it would cover all the states of the country excluding the Eastern States and the Union Territories. Thus the study area is restricted to 16 major states in the country. However the present report is based on the study carried out in the State of Maharashtra.

SAMPLE SIZE

The sampling procedures and sample size vary at various levels in the health organization and for various categories of respondents. The details for each are given below:

1. District: Conforming to the protocol specifications 10.0 percent random sample in States with more than 20 districts, two Districts in Karnataka were selected viz

   (i) Satara

   (ii) Parbhani

   (iii) Bhandara

.....37

2. PHCs: At each of the selected districts four primary health centres were randomly selected out of which one PHC had the dai training in progress at the time of investigation.

3. DAIS: From the available records of each of the 4 (four) sampled PHCs both trained and untrained dais, were selected randomly as below:

(i) One trained and one untrained dai from the village closer to PHC headquarters (within 5 kms.).

(ii) Two trained and two untrained dais belonging to any sub-centres of the PHC.

(iii) Any three trained and three untrained dais from any remote village beyond 5 kms. from the PHC headquarters.

Thus from each PHC six trained and six untrained dais were interviewed. If the sampled dais were not available inspite of repeated visits in selected villages, these were substituted by another dai (s) in the vicinity.

4. TRAINERS: Cent percent trainers at sub-centres and at the PHC level.

5. HEALTH WORKERS (F): In each PHC, 2 HW (F)/ANM of the sampled sub-centres were interviewed regarding their performance as trainer and technical guide to dai.

.....38

6. OTHER HEALTH OFFICIALS: (i) Medical officers incharge of selected PHCs regarding administrative problems and bottlenecks in the implementation of training; and (ii) District Level Officers including DHO concerned with the implementation, coordination and supervision of the training programme at the district level.

7. COMMUNITY: From each selected PHC, the mothers related to the last 5 cases as identified by each dai (both trained and untrained) who were delivered by her were interviewed. Thus the total number of mothers interviewed in each PHC works out to be 60 which includes 30 for trained and 30 for untrained dais.

Procedures for data collection:

Interview and observations schedules were developed to obtain information on the various aspects of dai training, the details of which are given below:

(a) Interview about their view regarding:

(i) aspects of dais profile.

(ii) suitability of training.

(iii) kit and its use and replenishment.

(iv) changes they have incorporated in their roles related to care of mothers and children and family planning activities.

(v) identification of further training needs.

(vi) interpersonal relation with ANM/HW (F) and

(vii) referrals to HW (F)/ANM/PHC.

2. The health workers (F) and auxiliary nurse midwives involved in the training and providing support and guidance to dais were interviewed to obtain information about:

(i) Registration of antenatal cases contacted by dais.

(ii) Collaboration with dais/HA (F)/LHV/particularly regarding cases referred by dais.

(iii) Interpersonal relations with trained/untrained dais.

(iv) Type of reinforcement provided to trained dais regarding:

- aseptic practices
- FP motivation
- nutrition education.

3. The mothers delivered by dais were interviewed with a vie to obtain their perception about:

   (i) dais acceptability;

   (ii) quality of her services; and

   (iii) competence and sociability of dai.

4. The interviews were also carried out with MO/PHN/DNS find out:

   (i) implementational problems in dai training at PHC/sub-centre level.

   (ii) implementational problems in Dai training at District level.

5. In one PHC where the programme for the training of dais was in progress at the time of field study, class-room observations were made to study the training process such as teaching learning situation, methods and aids used and efforts to involve the trainees.

6. The trainers were also interviewed to obtain information about their involvement of views regarding dai training programme.

.....41

I.4 D : PERSONNEL

A total six interviewers were employed for the purpose of field work in the three districts. The field workers were supervised by two Assistant Research Officers who stayed with the field team in the selected PHCs to supervise their work, scrutinising the filled-in schedules on a daily basis and find appropriate solutions to the field problems. The data collection operations were coordinated by the project Director through frequent personal visits to the field.

I.4 E : FIELD PROBLEMS AND CONSTRAINTS

In a study of this magnitude encompassing a wide number of aspects, some field problems and constraints are inevitable. A brief description of these problems is given below:

(1) Since most of the dais were not educated it was common for investigators to spend a good amount of time in convincing about the purpose of the investigation. Added to this, many of the dais attempted to ward off the interviewers by giving convenient answers.

(2) In some PHCs, where the study was undertaken, dais were given quotas of family planning cases and hence, the moment the team reached the village, dais would disappear.

.....42

(3) Problem of isolating the respondent was another pervading constraint. Villagers would flock around the subject and interviewer, often suggesting answers to the dai for particular questions.

(4) Location of untrained dais was a problem in almost every village. While trained dais were easily located in the selected villages the investigators literally hunted for the untrained dais. Many a times untrained dais had to be interviewed from the adjoining villages in order to match the trained dais.

.....43

REFERENCES:

1. Neumann, Alfred K., et.al. : Traditional Birth Attendants- A Key to Rural Maternal and Child Health and Family Planning Services, Environmental Child Health, February 1974.

2. UNFPA, Project Request Document, P.2.

3. Government of India, Protocol of Evaluation of Traditional Birth Attendants.

4. Neumann, Alfred K., and J.C.Bhatia: Family Planning and Indigenous Medical Practitioners, Social Science and Medicine, 1973, Vol.7, pp.507-516.

5. Verderse, M. deL and Turnbull, LM., : Traditional Birth Attendants in Maternal and Child Health and Family Planning- A guide to her training and utilization, WHO, Geneva, 1975.

6. Nicholas, DD., Ampofo, D.A., Ofasu-Amaah, S., Asante, R.O., and Neumann, AK., "Attitudes and Practices of Traditional Birth Attendants in Rural Ghana: Implications of Training in Africa, WHO Bulletin, Vol.54, Geneva, 1976.

7. Croley, H.T., Haider, SZ., Begum, S., Gusthafson, H.C., : "Characteristics and Utilization of Midwives in a Selected Rural Area of East Pakistan" Demography, 3 (2), Chicago, 1966, pp. 578-80.

.....44

8. Peng, JY, et.al. : "Village Midwives in Malaysia", Studie in Family Planning, Vol.3, No.2, NY, 1972.

9. Ibid.

10. Verderse, M. deL and Turnbull, LM., : Op Cit.

11. Neumann, AK., and Bhatia, JC., : Conclusions of Village Dai Interviews, unpublished study supported by USAID gran

12. Peng, JY., : Op Cit.

13. Bhandari, V. and Bhandari, U. : "Indigenous Dais: a study of 50 Cases", Family Planning News, 1970.

14. The Indonesian Planned Parenthood Association - Report on the Study of Dukuns in Central Hava, Jakartha, Indonesian Planned Parenthood Association, 1971.

15. Gardezi, HN., and Inayatullah, A. : The Dai Study, West Pakistan Family Planning Association, Lahore, 1969.

16. Croley, et. al. : Op Cit.

17. Brey, KH., : "Missing Midwife: Why a Training Programme Failed?", South Asian Review, 5 (1) London, 1971.

18. Verderse, M. deL and Turnbull, LM., : Op Cit.

.....45

19. Ibid.

20. Dwivedi, KN., and Rai, PH., : "The Training of TBA - A Broader Approach is Needed", International Journal of Health Education, 14 (1), Geneva, 1970.

21. Verderse, M. deL and Turnbull, LM., : Op Cit.

22. Gardezi, HN., and Inayatullah, A. : Op Cit.

23. Croley, et.al. : Op Cit.

24. Ahmad, W. : "On Traditional Birth Attendants in Pakistan", Studies in Family Planning, 2 (1), NY, 1971.

25. Neumann, AK and Bhatia, JC., : Op Cit.

26. Verderse, M. deL. : Consultation on the Role of Traditional Birth Attendants in Maternal and Child Health and Family Planning - Report of Review and Analysis and Information and Data on Traditional Birth Attendants, WHO, Geneva, 1973.

27. Nicholas, DD., et.al. : Op Cit.

28. Verderse, M. deL. : Op Cit.

29. Ibid.

.....46

30. Gordon, JE., Gideon, H., Wyon, JB., : "Midwifery Practice in Rural Punjab India, American Journal of Obstetrics and Gynaecology, a3 (5), St.Louis, 1965.

31. Verderse, M. deL : Op Cit.

32. Ibid.

33. Ibid.

34. Ibid.

35. Ibid.

36. Ibid.

37. Neumann, AK. and Bhatia, JC., : Op Cit.

38. Nicholas, DD., et. al. : Op Cit.

39. Gardezi, HN., and Inayatullah, A. : Op Cit.

40. Narang wal Rural Health Research Centre: Integration of Health and Family Planning in Village Sub-centres, Report on the Fifth Narangwal Conference, 1970, Ludhiana, 1970.

41. Dwivedi, KN., and Rai, PH., : Op Cit.

42. Rogers, EM., Solomon, DS., : Traditional Midwives as Famil Planning Communicators in Asia, Case Study No.1, East West Communication Institute.

43. Brey, KH., : Op Cit.

44. Neumann, AK., and Bhatia, JC., : Op Cit.

.....4

45. Mani, SB., : "Administrative Communication Problems in the Traditional Birth Attendants (TBAs) Training Programme in Tamil Nadu during 1975-76", Journal of Family Welfare, Vol.19, No.3, New Delhi, 1978.

46. Mani, S.B., : "A Review of Midwife Training Programme in Tamil Nadu", Studies in Family Planning, 11 (12), NY, 1980.

47. Ahmad, W. : Op Cit.

48. Gardezi, HN., and Inayatullah, A. : Op Cit.

49. Mugie, PC., : "Doctors and Dukuns-Puppets and Pills" - A Look at Indonesia's Family Planning Programme, IBRD, Washington DC., 1972.

50. Department of Health, Indonesia: Role of the Traditional Midwives in Family Planning Programme: Report of National Workshop to Review Researches into Dukun Activities Related to MCH Care and Family Planning, Jakartha, 1972.

51. Ibid.

52. Verderse, M. deL. : Op Cit.

53. Ibid.

54. Ibid.

55. Ibid.

56. Ibid.

57. Neumann, AK., et.al. : Op Cit.

58. Verderse, M. deL. : Op Cit.

.....48

CHAPTER 2

Dai Profile

CHAPTER 2

DAI PROFILE

A total of 130 dais were interviewed in Maharashtra, out of which 63 were trained dais and the remaining 67 were untrained. Among the trained dais, 42 or two-thirds were located at the Primary Health Centre (PHCs) and Sub-centre (SCs) villages and the remaining one-third were from remote villages. Among untrained dais, 38 or nearly 57% were from PHC and SC areas while the remaining 29 were from remote villages. The salient characteristics of dais interviewed are given below:

2.1: Age: An overwhelming majority (68.5%) of the dais interviewed were more than 45 years of age. In this category, 38 dais (42.7%) were trained while the remaining (57.3%) were untrained. Among 15 dais who are in the age group of 42-45 years, 9 were trained and 6 untrained. Another 14 dais, of whom 8 were trained, belonged to the age group 35-39 years. A look at Table 2.1 would show that the proportion of those in younger age groups is higher among the trained as compared to the untrained dais. The proportion of dais in different age groups are approximately equally distributed in the PHC/SC villages and remote villages.

2.2: Marital Status: The Marital Status of dais interviewed is given in Table 2.2. Almost all (96.2%) of the dais interviewed, notwithstanding their training status, were once

.....49

Table 2.1

Age distribution of dais in Maharashtra by traing status & location

Age groups	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Less than 19 years	-	-	-	-	-	-	-	-	1	3.5	1	1.5	-	-	1	2.0	1	0.8
20-24 years	-	-	-	-	-	-	-	-	1	3.5	1	1.5	-	-	1	2.0	1	0.8
25-29 years	3	7.1	-	-	3	4.8	1	2.6	-	-	1	1.5	4	5.0	-	-	4	3.1
30-34 years	3	7.1	2	9.5	5	7.9	1	2.6	-	-	1	1.5	4	5.0	2	4.0	6	4.6
35-39 years	4	9.5	4	19.0	8	12.7	2	5.3	4	13.8	6	8.9	6	7.5	8	16.0	14	10.8
40-44 years	6	14.3	3	14.3	9	14.3	3	7.9	3	10.3	6	8.9	9	11.2	6	12.0	15	11.5
45 +	26	61.9	12	57.1	38	60.3	31	81.6	20	69.0	51	76.1	57	71.2	32	64.0	89	68.5
	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....50

married and only 2 were single. In the ever married category, more than half (54.4%) were currently married and the remaining were widowed. A further break-up according to training status shows that 60.3% of the trained dais and 44.3% of the untrained dais were currently married. The remaining 39.7% of the trained dais were either widowed or divorced, while the proportion of untrained dais in this category works out to be 48.3%. Thus, proportion of currently married among the trained dais appears to be significantly higher than those of untrained.

2.3: Number of living children: As regards the number of living children of dais 59.2% had 3 or more living children, and 35.3% reported 5 or more living children. In the later category, the proportion of trained dais is significantly higher than those of trained dais.

2.4: Religion: An overwhelming majority (96.1%) of dais, both trained and untrained, were Hindus. While all the trained dais, excepting one, belonged to Hindus religion, among untrained dais 3 were Muslims and one was a Sikh. The religious affiliation of the dais is given in Table 2.4.

2.5: Caste: The distribution of dais according to caste is presented in Table 2.5 which shows that 47.7% of the dais belong to Scheduled Castes and Scheduled Tribes, another 23.1% were from 'middle castes' and the remaining 26.9% were from 'higher caste' group. Nearly half of the dais belonging

.....51

2181

Table 2.2

Marital status of dais in Maharastra according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Single	-	-	-	-	-	-	-	-	2	6.9	2	3.0	-	-	2	4.0	2	1.5
Married	23	54.8	15	71.4	38	60.3	17	44.7	13	44.3	30	44.8	40	50.0	28	56.0	68	52.3
Divorced/Seperated	2	4.3	-	-	2	3.2	0	0.0	1	3.5	1	1.5	2	2.5	1	2.0	3	2.3
Widowed	17	40.5	6	28.6	23	36.5	21	55.3	13	44.8	34	50.8	38	47.5	19	38.0	57	43.8
	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....52

Table 2.3

Number of living children of dais in Maharastra according to location and training status

No living child	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1	4	9.5	2	9.5	6	9.5	3	7.9	5	17.2	3	11.9	7	8.7	7	14.0	14	10.3
2	6	14.3	2	9.5	3	12.7	5	13.2	1	3.5	6	3.0	11	13.7	3	6.0	14	10.3
3	7	16.7	4	19.0	11	17.5	4	10.5	6	20.7	10	14.9	11	13.7	10	20.0	21	16.1
4	6	14.3	2	9.5	8	12.7	7	13.4	3	10.3	10	14.9	13	16.2	5	10.0	18	13.8
5	3	7.1	1	4.8	4	6.3	4	10.5	5	17.2	9	13.4	7	8.7	6	12.0	13	10.0
6	3	7.1	3	14.3	6	9.5	3	21.1	4	13.3	12	17.9	11	13.7	7	14.0	18	13.3
7 or more	4	9.5	3	14.3	7	11.1	3	7.9	2	6.9	5	7.5	7	3.7	5	10.0	12	9.2
Single	3	19.0	4	19.0	12	19.0	3	7.9	1	3.5	4	6.0	11	13.7	5	10.0	16	12.3
N.A.	-	-	-	-	-	-	0	0.0	1	3.5	1	1.5	-	-	1	2.0	1	0.8
	1	2.4	-	-	1	1.6	1	2.6	1	3.5	2	3.0	2	2.5	1	2.0	3	2.3
	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....53

Table 2.4

Distribution of dais by religion according to location and training status

Religion	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Hindu	42	100.0	20	95.2	62	93.4	34	89.5	29	100.0	63	94.0	76	95.0	49	98.0	125	96.1
Muslim	-	-	1	4.3	1	1.6	3	7.9	0	0.0	3	4.5	3	3.7	1	2.0	4	3.1
Sikh	-	-	-	-	-	-	1	2.6	0	0.0	1	1.5	1	1.3	-	-	1	0.8
	42	100.0	21	100.0	63	100.0	33	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....54

to scheduled caste/Tribes were trained. The proportion of trained and untrained dais falling in the above three broad caste groups is approximately the same and no significant differences are observable in the training status of dais according to caste. Furthermore, the dais belonging to different caste groups are randomnly distributed in the PHC/SC and remote villages and there does not appear to be any relationship between the caste of the dai and her location.

2.6: Educational Status: Educational status of both trained and untrained dais is given in Table 2.6 which indicates that 124 out of a total of 130 dais interviewed were reported to be illiterate; among the remaining 6 dais who were either literate or had some schooling; 4 were trained and 2 untrained. Furthermore, 5 out of these 6 dais were located in the PHC/SC villages.

2.7: Family vocation: A little more than three-fifths (61.5%) of the dais reported that attending to child births is their family vocation. The proportion of trained and untrained dais who inherited their profession works out to be 68.2% and 55.2% respectively. (See Table 2.7).

2.8: Husband's occupation: The occupational pattern of the husbands of dais is given in Table 2.8. Out of a total of 130 dais interviewed, 63 reported that their husbands were either dead, retired or unemployed. Among the remaining 67 dais who reported that their husbands were engaged in

Table 2.5

Distribution of dais by caste according to location and training status

Caste	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
High caste	10	23.8	6	28.6	16	25.4	11	29.0	8	27.6	19	28.4	21	26.2	14	28.0	35	26.9
Middle caste	11	26.2	6	28.6	17	27.0	11	29.0	2	6.9	13	19.4	22	27.5	8	16.0	30	23.1
S.C.	17	40.5	6	28.6	23	36.5	10	26.3	11	37.9	21	31.3	27	33.7	17	34.0	44	33.8
S.T.	4	9.5	3	14.3	7	11.1	4	10.5	7	24.1	11	16.4	8	10.0	10	20.0	18	13.8
Others	-	-	-	-	-	-	2	5.3	1	3.4	3	4.5	2	2.5	1	2.0	3	2.3
	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	30	100.0	50	100.0	130	100.0

.....56

Table 2.6

Educational status of dais in Maharastra according to location and training status

Educational status	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Illiterate	39	92.9	20	95.2	59	93.6	36	94.7	29	100.0	65	97.0	75	93.7	49	93.0	124	95.4
Literate	1	2.4	-	-	1	1.6	2	5.3	0	0.0	2	3.0	3	3.7	-	-	3	2.3
Primary	1.	2.4	1	4.8	2	3.2	-	-	-	-	-	-	1	1.2	1	2.0	2	1.5
Above Primary	1	2.4	-	-	1	1.6	-	-	-	-	-	-	1	1,2	-	-	1	0.8
	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	30	100.0	50	100.0	130	100.0

.....57

Table 2.7

Family vocation of dais in Maharastra according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Family vocation is dai work	27	64.3	16	76.2	43	68.2	20	52.6	17	58.6	37	55.2	47	58.7	33	66.0	80	61.5
Family vocation is not dai work	15	35.7	5	23.3	20	31.7	13	47.4	12	41.4	30	44.8	33	41.3	17	34.0	50	38.5
	42	100.0	21	100.0	63	100.0	33	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....58

economically gainfull occupational purpuits, an overwhelming majority (61.2%) were either owner-cultivators or landless labourers. Another 22% were engaged in household industry. The husbands of 6 dais were private medical practitioners. The occupation of the husbands does not seem to have any relationship with dais training status or location.

2.9: Main and secondary occupation of dais: The main and secondary occupation of dais are presented in Table 2.9 and 2.10 respectively. Three-fourths (75.4%) of the dais interviewed reported that attending to child birth was their main occupation. Another 13.8% reported that their main occupation is cultivation. The remaining 9.2% reported their main occupation to be agricultural labourer. The proportion of trained dais among those whose reported main occupation is other than dai works out to be 37.5%, while 52% of the dais, who stated their main occupation to be dai, were trained, These differences are substantial and appear to be significant. This is probably due to the reason that the dais who are engaged in other main occupational pursuits do not have time to undergo training.

2.10: Income: The information about the monthly family income, ascertained from dais is shown in Table 2.11 which indicates that 39 (30%) of the dais reported their total family income to be less than Rs. 100 per month. The reported monthly family income of another 60 (46.1%) dais ranged between Rs. 100 and Rs. 199. Another 23 (46.1%) dais stated their

.....59

Table 2.3

Occupation of dais' husbands in Maharastra according to location and training status of dais

Occupation group	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Widower/unemployed	19	45.2	6	23.6	25	39.7	22	57.9	14	48.3	36	53.7	41	51.2	20	40.0	61	46.9
Cultivator/agriculturist	7	16.7	3	14.3	10	15.9	3	7.9	5	17.2	8	11.9	10	12.5	8	16.0	18	13.3
Handless Labourer/ag. labour	6	14.3	5	23.8	11	17.5	7	13.4	5	17.2	12	17.9	13	16.2	10	20.0	23	17.7
Household industry/artisan	6	14.3	4	19.0	10	15.9	2	5.3	3	10.3	5	7.5	3	10.0	7	14.0	15	11.5
Service/Teacher	1	2.4	1	4.8	2	3.2	-	-	-	-	-	-	1	1.2	1	2.0	2	1.5
Retired	-	-	2	9.5	2	3.2	-	-	1	3.5	1	1.5	-	-	3	6.0	3	2.3
Traditional private practitioner	3	7.1	-	-	3	4.3	3	7.9	-	-	3	4.5	6	7.5	-	-	6	4.6
Don't know/can't say	-	-	-	-	-	-	1	2.6	1	3.5	2	3.0	1	1.2	1	2.0	2	2.3
	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

Table 2.9

Main occupation of dais by training status

Family Vocation	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Dai	32	76.2	19	90.5	51	30.9	25	65.3	22	75.9	47	70.2	57	71.2	41	82.0	98	75.4
Cultivator/ Agriculturist	6	14.3	2	9.5	8	12.7	5	13.2	5	17.2	10	14.9	11	13.7	7	14.0	18	13.8
Landless labourer/Agricultural labourer	3	7.1	-	-	3	4.8	7	18.4	2	6.9	9	13.4	10	12.5	2	4.0	12	9.2
Household industry	-	-	-	-	-	-	1	2.6	-	-	1	1.5	1	1.2	-	-	1	0.8
Housewife	1	2.4	-	-	1	1.6	-	-	-	-	-	-	1	1.2	-	-	1	0.8
	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....61

Table 2.10

Secondery occupation of dais in Maharastra according to location and training status

Occupation groups	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Dai	10	23.8	2	9.5	12	19.0	14	36.8	7	24.1	21	31.3	24	30.0	9	18.0	33	25.4
Cultivator/ Agriculturist	7	16.7	2	9.5	9	14.3	6	15.3	6	20.7	12	17.9	13	16.2	8	16.0	21	16.1
Landless labourer/ag. labourer	11	26.2	12	57.1	23	36.5	10	26.3	5	17.2	15	22.4	21	26.2	17	34.0	38	29.2
Household industry	4	9.5	4	19.0	8	12.7	5	13.2	4	13.8	9	13.4	9	11.2	8	16.0	17	13.1
Maid servant/ peon	1	2.4	-	-	1	1.6	-	-	-	-	-	-	1	1.2	-	-	1	0.8
Housewife	9	21.4	1	4.8	10	15.9	3	7.9	7	24.1	10	14.9	12	15.0	8	16.0	20	15.4
	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....62

family income was between Rs. 200 and Rs. 299. Only a few dais reported their monthly income as more than Rs. 300 per month. The difference in the family income with regard to trained and untrained are only marginal.

2.11: Professional experience: Table 2.11 shows the experience of dais in completed years. It is interesteng to observe that 62 (47.7%) of the dais reported that they had put in more than 15 years of work as birth attendants. The trained and untrained dais in this category are almost equally distributed. Another 22 (16.9%), of whom 14 were trained, had 10 to 15 years of experience, 24 (18.5%), of whom 9 were trained, had put in 5 to 10 years of experience as dais: 14 (10.8%), of whom 4 were trained, had upto 2 years experience as dais. Thus the dais with varying years of experience are almost equally distributed among trained and untrained and there does not appear to be any significant relationship between the dais experience and her training status.

2.12: Period lapse after training: The period lapsed after training is shown in Table 2.12. It can be seen from this table that of the 63 trained dais, only 2 dais were trained within a period of one year prior to the date of investigation, 24 (38.1%) were trained within 1-2 year prior to the date of interview and 35 (55.6%) received their training within 2-3 years of the date of interview.

.....63

Table 2.11

Monthly family income of dais according to location and training status

Monthly income (in Rupees)	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Less than Rs.100/-	16	33.1	6	28.6	22	34.9	3	21.1	9	31.0	17	25.4	24	30.0	15	30.0	39	30.0
Rs.100-199	14	33.3	11	52.4	25	39.7	21	55.3	14	48.3	35	52.2	35	43.7	25	50.0	60	46.1
Rs.200-299	8	19.0	3	14.3	11	17.5	7	18.4	5	17.2	12	17.1	15	18.7	8	16.0	23	17.7
Rs.300-399	3	7.1	-	-	3	4.8	-	-	1	3.5	1	1.5	3	3.7	1	2.0	4	3.1
Rs.400-499	-	-	1	4.8	1	1.6	-	-	-	-	-	-	-	-	1	2.0	1	0.8
Rs.500-599	-	-	-	-	-	-	-	2.6	-	-	1	1.5	1	1.2	-	-	1	0.8
N.A.	1	2.4	-	-	1	1.6	1	2.6	-	-	1	1.5	2	2.5	-	-	2	1.6
	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

Table 2.12

Total experience of dais in completed years in Manarastra by location and training status

No. of years of experience as dai	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Upto 2 years	3	7.1	1	4.3	4	6.3	1	2.6	-	-	1	1.5	4	5.0	1	2.0	5	3.8
3 to 5 years	4	9.5	2	9.5	6	9.5	3	7.9	5	17.2	8	11.9	7	3.7	7	14.0	14	10.8
5 to 10 years	6	14.3	3	14.3	9	14.3	8	21.1	7	24.1	15	22.4	14	17.5	10	20.0	24	18.5
10 to 15 years	9	21.4	5	23.8	14	22.2	4	10.5	4	13.8	8	11.9	13	16.2	9	18.0	22	16.9
15 + years	19	45.2	9	42.3	23	44.4	21	55.3	13	44.8	34	50.8	40	50.0	22	44.0	62	47.7
Can't say/ Don't know	1	2.4	1	4.8	2	3.2	1	2.6	-	-	1	1.5	2	2.5	1	2.0	3	2.3
	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....65

Table 2.13

No. of months lapsed after training by location of trained dais

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
4 to 6 months	1	2.4	0	0.00	1	1.6												
10 to 12 months	0	-	1	4.8	1	1.6												
13 to 15 months	11	26.2	6	23.6	17	27.0												
16 to 18 months	4	9.5	0	-	4	6.3												
22 to 24 months	2	4.8	1	4.8	3	4.8												
25 to 27 months	5	11.9	4	19.0	9	14.3												
28 to 30 months	4	9.5	2	9.5	6	9.5												
31 to 33 months	2	9.5	1	9.5	3	4.8												
34 to 36 months	0	4.3	3	4.3	3	4.3												
36 & more months	13	30.9	1	4.3	14	22.2												

CHAPTER 3

Organization of Training

CHAPTER 3

ORGANIZATION OF TRAINING OF DAIS

This chapter deals with the procedures followed in the organization of dai training programme by the health functionaries who are directly involved in this training. The discussion includes the profile of trainers, selection procedures, perception of trainers with respect to the maternal and child care practices of dais, training processes, evaluation of trainees, and observation of class room teaching.

3.1 Designation of Trainers

The training of dais in the State of Maharashtra is primarily conducted by Health Workers (Female)/Auxiliary Nurse-Midwives under the supervision of Health Assistant (Female)/Lady Health Visitors. These supervisors are responsible for scheduling the training and seeing it through the entire process. Out of 14 trainers (HW(F)/ ANMs) interviewed, 13 were located at the PHC headquarters, while only one was located at the sub-centre. The HA(F)/LHVs and Medical Officers (MOs), who are located at the PHC headquarters, also provide their inputs to the training by conducting a few class room sessions. Whenever the training is organized at the sub-centre, the HA/LHVs make frequent visits for the purpose of supervising the training programme and for providing their inputs. The medical officers of PHC also sometime visit these sub-centres during the course of training to provide necessary guidance and to see if the guidelines laid down for the training are properly followed.

.....67

3.2 Marital Status

Of the 14 trainers interviewed 5 (35.7%) were unmarried, 8 (57.1 were currently married and 1 (7.1%) was a widow. (Appendix Table 3.1)

3.3 Educational Status

The educational status of the trainers is shown in Table 3.2 which indicates that approximately one-third (35.7%) of the trainers reported that they had studied upto the middle level another about one-fifth (21.4%) reported education upto high / school level, and the remaining approximately two-fifths (42.9%) reported that they were educated upto higher secondary level.

3.4 Experience as a Professional

It could be seen from Table 3.3 that 6 (42.9%) trainers had professional experience of 1-2 years, 4 (28.6%) had 3-4 years of professional experience. One trainer each is reported to have 5-6 and 7-8 years experience respectively. Thus, most of the trainers had put in less than 4 years in their current profession.

3.5 Experience as Trainer

All the trainers reported that they had prior experience of training the dais, though the number of batches of dais trained by them varies. Out of a total of 14 trainers interviewed, half reported that they had already trained upto 4 batches of dais. Three trainers (21.4%) each reported to have trained 5-6 and more than 7

batches respectively (Appendix Table 3.4). So far as number of dais trained by each trainer is concerned, 4 trainers reported that they had trained upto 20 dais each. Another 4 reported to have trained between 30-50 dais. There were three trainers who reported that the number of dais trained by them ranged between 50 and 60 (Appendix Table 3-5).

3.6 Selection Procedures

(a) Source of information regarding dai training programme

All the trained dais were asked how they came to know about the existence of dai training programme in their area. Of the 63 trained dais interviewed 35 (55.6%) reported that they came to know about the dai training programme in their area through the various government health functionaries. Another major source of information reported was the community leaders which was mentioned by approximately one-third (30.2%) of the dais who had already undergone training. A small proportion of the dais also reported to have received information about dai training from other dais in the area and friends or relations.

A further break up of sources of information according to the dais location reveals that a slightly higher proportion (61.9%) of those located in PHC/SC villages came to know about the dai training programme from health functionaries as compared to those living in the remote villages (52.4%). However these differences are marginal and do not appear to be statistically significant.

.....69

(b) Motivation for Training

All the trained dais were asked as to who motivated them to undergo the training. The dais were encouraged to report if they were motivated by more than one person. The multiple responses so elicited are given in Table 3.7. The tables shows that the health functionaries were the major motivating force and next in order of importance were the community members. The proportion of those motivated by the community is slightly higher in the remote villages as compared to the dais from PHC/SC villages. This is in conformity with the data about the sources of information and there too the differences are not very marked.

(c) Criteria for selection of trainees

The trainers and medical officers were asked to indicate the important considerations for selecting the dais for the training programme. The multiple responses elicited from them are shown in Table 3.8. As could be seen from the table, according to the trainers, dais residence in the village, her interest in improving her performance as a dai, competence and popularity were some of the criteria used for enlisting the dais for the training. The recommendations from the health functionaries and community leaders were also reported to have been given due consideration.

Multiple responses elicited from the medical officers incharge of PHCs reveal that out of 19 medical officers interviewed i the

.....70

three districts of Maharashtra, most indicated that dais age (16), experience (18), competence (12), popularity (16) belonging to a remote area (15) location in a village which has no other dai (12) were important considerations for enrolling the dais for the training programme. The caste, economic backwardness and education, according to the medical officers, were not given much weightage.

(d) Problems related to Selection

Out of 19 medical officers interviewed, 15 indicated that they did not encounter any problems relating to the selection of dais for training and the entire selection process went on smoothly. However, the remaining 4 medical officers reported that sometimes certain sections of the community and some individual dais did not agree with the selections made and sent in their representations. The general complaint of the community in such cases was that incompetent and unpopular dais have been selected for training on the recommendations of certain vested interests, and overall views of the community have not been taken into consideration. A few dais who were not selected for training also put forth their claims on the basis of better skills and professional experience. These issues were resolved through a process of discussions with the petitioners and community leaders, both formal and informal.

3.7 Planning for Training

The total as well as districtwise budgetary allocation for training, including stipends paid to trainees, is made at the

State level. The kits and other equipments needed for the training such as AV aids, charts etc. are also procured by the State Family Welfare Bureau and distributed to districts. The districtwise targets for dai training are also fixed by the State Bureau and communicated to each district. The allocation of funds and equipment to districts is primarily based on the targets so fixed. The District Health and Family Welfare Officers, in turn, fix targets of dai training for all the PHCs under their respective jurisdictions and prepare necessary plans for scheduling the training in each PHC. The distribution of kits, stipend money and training materials to the respective PHCs, is based on the targets and their implementation by the PHCs. In this work the District Health and Family Welfare Officer is assisted by an Assistant District Health Officer (ADHO) who is responsible for overseeing the dai training programme in the entire district.

At the PHC level, the medical officer incharge prepares the annual plan for dai training at different locations in the PHC area taking into consideration the availability of manpower, their workload, existing facilities and needs of the population. The Medical Officer also helps the trainer in scheduling the class-room sessions and providing general guidance and support in the conduct of training. He is also responsible for distribution of kits and stipends to the trainees. Many a times the medical officer personally participates in the training programme by conducting a few class room sessions particularly when the training is organised at the PHC headquarters. At the sub-centre, the trainer works under the supervision of

Health Assistant (F)/Lady Health Visitor, who in turn keeps the medical officer informed of the progress and obtains necessary instructions for successful implementation of the training programme.

3.8 Implementation of Training Programme

(a) Location: Out of 12 PHCs in three districts of Maharashtra included in this study, only in one PHC the dai training programme is reported to have been conducted at the sub-centre level. In the remaining PHCs the training programme had been carried out at the PHC headquarters only. The main reasons for organising the training at the PHC headquarters, as reported by the trainers and other health functionaries, are the availability of facilities for teaching and demonstration at the PHC headquarters. It was indicated that the sub-centres lack necessary facilities requested for an effective conduct of the training programme. In one PHC where the training programme is conducted at the sub-centre level, the trainers often bring the trainees to the PHC headquarters for the purpose of demonstration and other clinical training. This results in considerable waste of time and causes a lot of inconvenience, both to the trainers and the trainees.

(b) Training Process:

The training process has been examined in terms of duration and scheduling of the training programme; assessment of odd beliefs and practices of dais as perceived by the trainers; contents covered

in the clinic, class room and field; teaching methods followed including aids used; and the procedures followed for the evaluation of trainers.

(bi) Duration and Scheduling:

The scheduling of the training programme which includes time table lesson plans, field visits etc. is done at the district level. The medical officers, however, reexamine these schedules and are allowed to make minor, though not substantive, changes in these plans, to meet the local situation and exigencies. The training programme in all the 12 PHCs studied is reported to have lasted for 30 working days, as per the guidelines provided by the district authorities. However, it was indicated by many trainers and medical officers, that they could not exactly follow the plans given by the district authorities and slight modifications had to be made in the time table to suit the needs of trainers and trainees at the field level, as well as other exigencies of work.

(bii) Assessment of odd beliefs and practices:

The training programme is primarily meant to bring about an improvement in the dai practices. These dais have certain odd beliefs and practices, which at times are harmful to the mother and the child. The training attempts to remove these harmful beliefs and practices through proper education and persuasion. Many of these beliefs and

practices are local in nature and differ from one area to the other. The trainers must be familiar with these beliefs and practices in order to be able to make the training effective according to local needs and requirements. The trainers were, therefore, asked to report the odd beliefs and practices of dais in their respective areas, as perceived by them. Some of these beliefs and practices relating to antenatal, natal and postnatal care, as reported by the trainers, are given below. The figures in the parenthesis represent the number of responses.

(1) Antenatal: The pregnant women are advised not to rest in the afternoon (6); the immunization of pregnant woman results in the death of child in the womb (6); Iron and folic acid tablets are harmful for the child in the womb.

(2) Natal: It is better to deliver the child in the cattle shed (9); the delivery should preferably be conducted in a dark closed room so that air can not get in (12).

(3) Post-natal: Use of sickle, stone and other unsterilised instruments to cut the cord (10); dressing the cord with ash, ghee, oil etc. (3); the mothers are advised not to give first days milk to the newly born baby (7); immunizing the child and the mother serves no useful purpose (5); immunization is harmful and results in many complications (6).

.....75

(4) Family Planning: The methods of family planning such as IUD and sterilization are harmful (5); indifferent or adverse attitudes towards family planning (9). (Appendix Tables 3.9 to 3.9e).

The trainers reported that they try to ascetain these belief through discussions with the community and the dais and by direct observations. The knowledge of these odd beliefs and practices i helpful to them and they try to educate the dais to discard some of these beliefs and harmful practices.

(biii) Components of training:

The information obtained from the trainers reveal that a large proportion of the training time was spent on field activities, both supervised and unsupervised. All the trainers reported that the class-room teaching and clinical demonstrations were carried out at the PHC headquarters. However, number of days reported to have been spent in class-room teaching vary a great deal from trainer to trainer. Out of 14 trainers interviewed, 7 could not specify the number of days spent in class-room teaching and insisted that they followed the guide-lines provided in this connection. Two trainers reported that out of 30 days of training, classes were scheduled only for two days; one trainer reported that 7-8 days were spent on class-room teaching, while three trainers are reported to have spent more than 11 days on class-room activity (Appendix Table 3.10).

.....76

As regards number of days spent on clinical activities, here again, 7 trainers insisted that they followed the prescribed guidelines. Two trainers informed that they allotted two days for clinical demonstrations, another 3 trainers reported that they spent 3-4 days on clinical sessions. One trainer reported that about half of the training period i.e. 15-16 days were devoted to clinical training. (Appendix Table 3.11).

With respect to field activities, 8 out of 14 trainers reported that the trainees were taken to the field according to the training plan given to them and could not specify the exact number of days. Two trainers reported that trainees spent 13-14 days on supervised field activities, another two trainers reported that only two days were spent on this activity (Appendix Table 3.12).

As far as unsupervised field activities are concerned, while half the trainers reported to have followed the guidelines, 5 trainers were unable to specify the number of days spent by the trainees on these activities. Two trainees reported that the trainees were sent to the field to perform certain assigned tasks without any supervision and report back (Appendix Table 3.13).

Information was also collected from the trainers about the average time spent per day on different component of training i.e. class-room, clinical and field. Regarding class room activities, half the trainers reported that they followed the guidelines. Two trainers

indicated that they spent 5-8 hours daily on class-room sessions; one trainer reported that she spent from 1-4 hours a day on class-room teaching. The remaining 4 trainees could not specify the number of hours spent of this training activity (Appendix Table 3.14).

The pattern of responses for clinical part of the training is similar to those for class-room teaching. (Appendix Table 3.15).

An overwhelming majority of the trainers could not specify the number of hours spent per day on supervised and unsupervised field activities. Most of them reported that they follow the guidelines given to them and a few who could specify the number reported that they spent more than 9 hours daily on the field component of the training (Appendix Table 3.16 and 3.17).

It is thus apparent from the responses of the trainers that allocation of time on the various components of the training as well as time devoted per day to various training activities widely vary.

(biv) Contents covered:

The trainers were asked to specify the topics which were covered during the training. The antenatal and postnatal care was reported by 8 out of 14 trainers interviewed. The management of normal delivery and need for immunization were mentioned by 4 and 3 trainers respectively. Further, 2 trainers reported that care of the new born was included in lesson plans. The other important topic

such as aseptic techniques, nutrition, and family planning received very little attention in the lesson plans and were mentioned by only one trainer each. (Appendix Table 3.17). It may be appropriate to mention here that due to spontaneous nature of the responses, the topics listed are not necessarily mutually exclusive.

(bv) Methods of teaching:

Methods of teaching reportedly employed by the trainers included lectures, discussion, demonstration, role play, and observational visits to the field. All the 14 trainers interviewed reported that they used the above mentioned methods except role play which was mentioned only by 5 trainers. (Appendix Table 3.18). However it may be mentioned here that the emphasis laid on a particular method of teaching varied from trainer to trainer. Whenever, the Medical Officer, PHC conducted the class room sessions lectures were combined with discussions and demonstrations. Further, information was also elicited with regard to teaching methods used for imparting knowledge about various family planning techniques. The methods used varied with the techniques. For example, Nirodh, Foam Tablets, Jelly, Oral pills were first showed to the trainees and then their importance and mode of operation was discussed. With respect to IUD, sterilization and MTP, lectures and discussions were followed by actual demonstrations (Appendix Table 3.19).

.....79

(bvi) Demonstrations conducted:

As mentioned above, demonstration as a method of teaching was reported to have been widely used by the trainers to improve the effectiveness of the training programme. The trainers were further asked to give details of the demonstrations and the situations under which this method of training was used.

The information elicited from the trainers reveal that half the trainers demonstrated the techniques of sterilizing various instruments. Another 9 trainers reported that they gave actual demonstrations for maintaining personal hygiene and cleanliness such as cutting of nails, wasting of hands with soap etc. One trainer also reported t to have demonstrated the use of antiseptics such as detol, and two trainers reported that they gave demonstrationwith respect to proper environmental sanitation/clean delivery place. (Appendix Table 3.20).

Demonstration given with respect to general health check up of mothers and children included various aspects. A little more than one thirds of the trainers (35.7%) reported that carrying out regular check up of pregnant women beginning third month of pregnancy was demonstrated to trainees. Seven or exactly half the trainers interviewed reportedly demonstrated the importance of balanced and nutritious diet. Other demonstrations given in this respect included, among others, post-natal care, infant care, identification of complications among mothers, urine and blood test (Appendix Table 3.21).

.....80

Regarding immunization, a little more than two fifths (42.9%) the trainers reported that they had demonstrated the administration of tetanus toxoid to mothers, nearly four fifths (78.6%) reportedly demonstrated the administration of small-pox vaccine, BCG, DPT, Polio to infants upto six months. Two trainers indicated that they had given demonstration of booster dose of DPT and Polio vaccine for children upto 3 years of age (Appendix Table 3.22).

Demonstration regarding management of Labour, as reported by trainers, includes the following.

How to listen to foetal heart beats (1);

Conduct of Labour (3);

Sterilization of instruments before use (7);

Placing mother in comfortable position (3);

Waiting for expulsion of placenta (1);

(Figures in parenthesis indicate the number of responses)
(Appendix Table 3.23).

With respect to the preparation of home confinement almost all trainers reportedly demonstrated aspects such as maintaining clean ventilated room, preparation of clean pads and use of rubber sheets etc.

.....81

Information was also collected regarding demonstration given with respect to family planning. The data show that a little more than two fifths (42.9%) of the trainers interviewed had demonstrated the insertion IUD and use of Oral Pills. 4 trainers (28.6%) had actually demonstrated sterilization operations and roughly three fourths (71.4%) claimed to have demonstrated the proper use of Nirodh. As mentioned elsewhere, it would be pertinent to add here that demonstration of these techniques vary from just showing the items to actual demonstration of the use of these methods (Appendix Table 3.24).

(bvii) Aids Used: Our interviews with the trainers and the medical officers of primary health centres indicate that the training facilitie are inadequate both at the PHCs as well as at the sub-centres. The situation is particularly bad at the sub-centre where even the basic equipment required for training such as blackboard with chalk, dummy with foetal doll models, charts etc are not available. It was reported by the trainers that whenever the training is organised at the sub-centres have to be brought to the PHC headquarters for clinical training and demonstration because of absence of these facilities at the sub-centres. This greatly affects the quality of training given to dais at sub-centres (Appendix Table 3.25). Further 16 out of 19 medical officers complained about the non-availability of audio-visual aid and obstetrical manukins, 8 medical officers reported that supply of equipment for sterilization is not all sufficient, 11 medical officers indicated that maternity kits are supplied in time and according to the requirements.

(bviii) Other problems during training:

Out of 16 medical officers interviewed 7 reported that there is considerable delay in the payment of stipends to the trainees due to administrative problems at the district level, 6 the other problems which were commonly reported by the medical officers were replenishment of kits due to non-availability of adequate supplies and additional funds for the purpose. Some medical officers also felt the difficulty in translating technical terminology into local language which can be easily understood by the trainees who do not have sufficient educational background (Appendix Table 3.26). In addition organization of practicals was reported to be a major problem. This according to medical officers as well as the trainers was primarily due to short duration of the training programme. The field demonstration of cases of delivery, and other allied aspects were dependent upon the abailability of cases, which depended on a number of seasonal and other factors.

(bix) Evaluation of trainees: The trainees, after having undergone 30 days training are formally evaluated by the trainers as well as other PHC staff. The interviews with the trainers and the medical officers indicate that normally an oral examination is given at the end of the training period in which trainees are asked questions relating to the contents covered during which include ante-natal care, post-natal care, conduct of normal delivery aseptic techniques conditions for referral, care of the new born and family planning methods (Appendix Table 3.27).

.....83

The training programme: The trainees are, however, not systematically followed up after the training by any of the PHC staff. This according to the medical officers and trainers, is due to heavy work load which does not permit a separate schedule for evaluating the performance of trained dais in a systematic manner. Further, evaluation of the training programme as such, has not so far been conducted in any of the PHCs included in this study.

(c) Observation of class room teaching

Observation of the training programme was an important part of our investigation. At the beginning of data collection, it was planned to observe the class room as well as field sessions in atleast one PHC of each district covered. Unfortunatedly, this objective could not be accomplished due to the following reasons:

(a) At the time of investigation, many PHCs had completed their training targets.
(b) Many PHCs were busy in completing the family planning targets in their respective areas.

However, a class room session was observed in Jamb PHC of Parbhani district. The results of this observation are given below:

The topic of the session, which lasted for 45 minutes, was 'home delivery'. The class was held in a room in the PHC building.

The trainees were seated on a bench and the trainer on a chair facing the trainees. The session was conducted on the basis of a prepared lesson plan. Although the black board was available in the class room, it was not used during the session. The trainer extensively used local dialect and the technical terms were explained in the language which the trainees appeared to understand by and large, trainer did not have any difficulty in communicating with the trainees. The methods of teaching used during the session included demonstration, return demonstration and discussion. Maternity kit was used for demonstration. The trainer put questions to the trainees which revolved around the cases earlier shown to the trainees in the field. They were encouraged to discuss the problems among themselves and provided sufficient opportunity for the purpose. The trainer repeatedly asked questions to ascertain if the trainees had understood, the topic properly and provided clarifications wherever needed. Whenever, any question was raised by trainee; the trainer asked other trainees to respond. During demonstration, the trainer involved the trainees were asked to give a return demonstration. During return demonstration by the trainees, the trainer immediately corrected any errors made by the trainees. The relation between the trainer and the trainees appeared to be cordial and free and the trainer often shared his/her past experiences with the trainees.

.....85

CHAPTER 4

Efficacy of Training

CHAPTER 4

EFFICACY OF TRAINING

In this chapter, an attempt has been made to measure the effectiveness of various components of the training programme, and their impact on the overall performance of dais. This has been done by analysing the process of inputs into the training programme, capability of trainers, methods followed for evaluation, monitoring and follow up of trainees, type and equality of services provided by dais and overall satisfaction of women delivered by them.

4.1 INPUTS PROCESS

The pattern of inputs into a training programme, to a large extent, depends upon the availability of training facilities at the place of training. As has been mentioned in the previous chapter, trainers as well as medical officers incharge of primary health centres (PHCs) interviewed reported that availability of important training equipments such as audio-visual aids, models, charts etc. is inadequate. This is further corroborated to some extent by the results of our interviews with the district level officials. Out of 8 district level officials interviewed 4 reported that audio-visual aids and dummies with foetal doll are not available in required quantities. Furthermore, 3 officials complained about the problem of distributing adequate maternity kits

.....86

to PHCs, and 4 officials stated that there is no budgetary provision for the replenishment of maternity kits and so th same is not being done. However, none of the district leve officials reported any problems with regard to the distribu tion of stipends, supply of sterilization equipments and class room furniture etc. to the training centres. Since m of the dais are either illiterate or have very low educatio level, there is an urgent need to equip the training centre especially the sub-centres, with adequate training facilitie particularly items like audio-visual aids, charts, atlases, models etc. to make the contents of training more interestin and easily intelligible to the trainees.

The nature and quality of training imparted is also pro posed to be measured by variables such as perception of trai ners regarding major functions of trained dais, cooperation from trained and untrained dais, short-comings found in the practices of untrained dais and improvements observed in trained dais, specific guidance provided to dais during follow up visits, problems encountered during the training period, methods used to help trainees who are slow in learn- ing, and mechanisms used for ensuring that right type of skills are imparted to the trainees. In the following para- graphs, we endeavour to discuss some of these aspects.

As regards perception of trainers regarding major functions of trained dais, it is surprising to note that 6 out of 14 trainers interviewed were not able to specify the functions the trained dais are supposed to perform. The remaining 8 trainers gave multiple responses which mainly focus on management and conduct of normal and safe delivery using aseptic techniques, registration of pregnant women for ante-natal care, referral for complications, cooperation in immunization programmes, and promotion of family planning (Appendix Table 4.1).

All the trainers reported that, by and large, they receive cooperation from the trained dais in the performance of their duties. The type of cooperation received, as reported by trainers, include registration of births and deaths, registration of pregnant women for ante-natal care, administration of tetanus-toxoid to pregnant women, referral of complicated cases, post-natal case, primary and revaccination of children, and motivation for family planning (Appendix Table 4.2). As regards cooperation from untrained dais, nearly three-fifths (57.1%) of the trainers interviewed reported that the untrained dais generally do not associate with them and they receive very little cooperation from them in the performance of their day to day functions. The remaining 42.9% of the trainers reported that they receive help from the untrained dais in the registration of pregnant women for

.....88

ante-natal care, referral of complicated cases, post-natal care, and immunization of infants and children (Appendix Table 4.3).

Information was also collected regarding the shortcomin of dais, as observed by trainers, and which need to be impro ved through proper training. Multiple responses elicited in this regard are shown in Appendix Table 4.4. As could be se from this table an overwhelming majority of trainers (85.7%) reported that the dais lack personal hygiene, do not boil t instruments used for conducting the delivery and cutting the cord. Further 9 out of 14 trainers informed that while conducting the delivery the dais, put the pregnant women in uncomfortable position, often on unclean floor. Other shortcomings reported by trainers are that the dais do not allow sufficient time for expulsion of placenta, try to pull the child forcibly from the womb, do not take proper care of the cord etc.

The trainers were also asked to report improvements observed in the dai practices as a result of training. In this connection 9 (64.3%) of the trainers reported that trained dais observed better personal hygiene; 10 (71.4%) informe that trained dais sterilize the instruments, pads and ligates before use; 6 (42.9%) stated that trained dais place the wome for delivery in a relatively more comfortable position. The other improved practices observed by trainers among trained

dais and reported by them are listed below. The number of responses are given in the parenthesis:

(a) Following instructions given during training (1),

(b) Making effort for better antenatal care (2).

(c) Advising pregnant women for regular check up at sub-centre/primary health centre (1).

(d) Advising pregnant women and referring them to PHC/SC for tetanus-toxoid (1).

(e) Using maternity kit and proper instrument, such as scissors for cutting the cord (2).

(f) Using rubber sheet (1).

(g) Using clean cloth for padding (1).

(h) Taking proper care of cord (1).

(i) Giving proper bath to baby (3).

(j) Proper preparation for delivery and giving anema to pregnant women (1). (Appendix Table 4.5).

The trainers reported that they employ a variety of methods to make sure that right kind of skills are imparted to the trainees and also to make the lessons easily intelligible to the trainees who are relatively slow in learning.

A little more than one-third (35.7%) of the trainers reporte that they ask questions from the trainees during and after t sessions; 4 (28.6%) trainers reported that they provide enou time and opportunities to trainees to discuss the topic amon themselves; 3 (21.4%) trainers reported to be ascertaining through return demonstrations by trainees that the technique taught have been clearly understood by them; 2 (14.3%) train mentioned that they observe the trainees when they are actua conducting deliveries and make sure that the knowledge about improved midwifery practices imparted to them properly has been followed. Another trainer stated to have been conducti frequent oral tests to ensure that the trainees have followe the lessons properly (Appendix table 4.6).

Regarding techniques used to help the trainees who are slow in learning, 11(78.6 %) of the trainers reported that t repeatedly explain, clarify, discuss and demonstrate the aspe which are not easily understood by the trainees; 5(35.7 %) o the trainers informed that they explain the difficult points different ways giving examples from local situations which a often encountered by the trainees, and 4 (28.6%) trainers men tioned that the slow learning trainees are involved in the actual conduct of deliveries under their close supervision and the improved practices are explained and demonstrated to them (Appendix table 4.7).

.....9

4.2 MONITORING OF TRAINING PROGRAMME

Our interviews with the various health functionaries reveal that there is no regular and systematic effort to effectively monitor the training programme. This is reported to be due to excessive work load and competing demands on the time of various categories of PHC personnel. All the medical officers incharge of PHCs reported that the training programmes are not adequately followed up and supervised by the HA(F)/LHVs. Out of 19 medical officers interviewed 10 reported that they do not receive regular follow up reports of the training programme from the concerned health workers. The remaining 9 medical officers stated that the health workers responsible for conducting the supervising the dai training programme report the progress verbally during monthly PHC staff meetings. Further, the medical officers also reported that on their routine visits to the villages and sub-centres they discuss the progress of the dais training programme with the health workers and also ascertain from the community the improvements, if any, observed in the practices of dais as a result of training.

The district level officials connected with the dai training programme also reported that they do not receive regular reports from the PHCs about the progress of training programme. These officers further reported that whenever a report is received from a PHC they immediately provide their

feedback and suggestions to bring about an improvement in th training programmes. In the absence of follow-up reports fr PHCs, the district level officials, such as Assistant Distri Health Officers and Public Health Nurses, who are charged wi the responsibility of overseeing the dai training programme the district visit the PHCs and provide necessary guidance and support.

There is thus an urgent need for a proper reporting syst both at the PHC and district level to effectively monitor the progress of the training programme. This will facilitate identification of problem areas and ensure early remedial mea sures, for bringing about improvements in the various aspects of dai training programme.

As regards follow up of dais after training, 13 out of 14 trainers reported that they regularly follow up the traine dais and report the same to the medical officers. When asked about specific guidance provided to the trained dais during their follow up visits, 7 (50.0%) trainers reported that they advise dais to register pregnant women for antenatal care, 4 (28.6%) reported that they instruct dais to refer pregnant women to SC/PHC for tetanus-toxoid injections, another 4 (28. mentioned advising dais to sterilize the instruments before u and yet another 4 (28.6%) trainers stated that on their follo up visits they advise the trained dais to motivate cases for family planning. The other aspects on which guidance is

.....

reported to be provided include referral of complicated cases to SC/PHC, advising pregnant women to take iron with folic acid tablets, use of maternity kits, proper handling of newly born babies etc. (Appendix Table 4.8).

4.3 PROBLEMS DURING TRAINING

According to the trainers, the main problem encountered by them during the training was difficulty in making the dais understand the lessons due to the latter's illiteracy and low educational level. The second problem mentioned by the trainers was the non-availability of audio-visual aids and other teaching materials such as models, charts obstetrical mankin etc. One of the trainers also reported that their seniors were often not available for conducting classes and for providing other inputs to the training programme. While illiteracy or low educational level of trainees is a major bottleneck calling for simple methods; inadequate training facilities, which is amenable to administrative solution, was another problem mentioned by the trainers.

4.4 SUPPORT AND GUIDANCE FROM SUPERVISORS

With respect to the pattern of support and guidance received by the trainers in the conduct of dai training programme, most of the trainers reported that their supervisors i.e. medical officers and HA (F)/LHVs provided necessary help

.....94

and guidance in many aspects of training such as scheduling of class room sessions, scheduling of immunizations, giving demonstration to trainees, and actual participation in class-room sessions etc. An overwhelming majority of trainers (78.6%) reported that their supervisors actively participated in lecture sessions (Appendix Table 4.9).

4.5 TRAINEES, TRAINERS and ORGANIZER'S SATISFACTION WITH TRAINING PROGRAMME

(a) TRAINEES: An overwhelming majority (95.2%) of the train dais interviewed reported that the training programme wa helpful to them in a variety of ways. The reasons given in support of their answers are listed below with number of responses in parenthesis:

(i) Learnt new techniques not known earlier (13).

(ii) Learnt scientific methods of conducting delivery (1

(iii) Better skilled than before in attending to complications (11).

(iv) Came to know of importance of immunization (4).

(v) Can now advise on personal hygiene (9).

(vi) Use sterilized instruments to avoid tetanus (8).

(vii) Can advise on family planning methods and their proper use (4).

.....95

(viii) Get better recognition from the community.
(Appendix Table 4.10).

Our study shows that the dais in general expressed their overall satisfaction with the training programme and the way it was executed. They felt that the training has resulted in the improvement of their professional skills.

(b) TRAINERS: Out of 14 trainers interviewed, 5 reported that they were 'highly satisfied' with the training programme. The main reason mentioned by them for their view is that the dais have followed their instructions exactly according to their expectations. Another 8 trainers revealed that they were 'satisfied' with the training programme. The reasons given in support of their answers are given below:

(i) The dais have learned, to some extent, what was taught to them.

(ii) There has been improvement in the practices of trained dais.

(iii) The trained dais, by and large, follow the instructions given to them during the course of training.

.....96

One trainer who reported least satisfaction with the training programme was unable to support her view with adequ reasons.

(C) ORGANIZERS: All the medical officers incharge of prima health centres (PHCs) interviewed to ascertain their views about the training programmes conducted in their respective areas, expressed their overall satisfaction with these pro- grammes. However, there is a great variation in the extent satisfaction as well as the reasons underlying their expresse satisfaction. Out of 19 MOs interviewed, 6 reported that the were 'highly satisfied' with the training programme. The rem ing reported that they were 'somewhat satisfied'. The 'highl satisfied' MOs gave following major reasons for their views:

(i) Midwifery practices of dais have greatly improved as a result of training.

(ii) Trained dais are conducting deliveries in a satisfactory manner.

(iii) The dais have followed the instructions given to them during training and are acting upon them.

The remaining 13 MOs reported that they were 'somewhat satisfied' with the training programme. The reasons advanced in support of this view are as follows:

(i) The dais bring pregnant women for ante-natal registration and motivate women for family planning.

(ii) No proper remuneration is given to dais and hence, they do not take expected interest in their work.

(iii) People think that trained dais are paid by government and hence, do not pay for their services.

(iv) A separate health worker like LHV or any other person should be solely in charge of the training programme.

(v) Not many complicated delivery cases are reported by trained dais.

(vi) The trained dais are not very much experienced in their profession.

(vii) ANMs incharge of sub-centres are difficult to reach due to transport difficulties and hence, follow up of trainees as well as dais is difficult.

(ix) The dais from remote areas are not willing to undergo training.

(x) Most of the dais are illiterate and hence, difficult to communicate with them on technical aspects of midwifery.

Regarding extent of satisfaction of district level officials with the training programme, out of 8 district level officials interviewed, 6 disclosed that they were "some what satisfied" with the training programme, and the remaining 2 reported that they were "highly satisfied".

Reasons in support of their views are given below:

(i) The training programme is not sufficiently publicised.

(ii) Many dais who are located in interior villages are not easily accessible for regular supervision and follow up.

(iii) There is greater emphasis on class room teaching rather than demonstration.

(iv) The follow up of trained dais by trainers is inadequate.

(v) The trained dais are now conducting normal deliveries much more safely and they also motivate women for family planning.

The results of our interviews with the health functionaries at various levels shows that the trainers and organizers, on the whole, are quite satisfied with the training programme notwithstanding certain problems. However, inadequate training facilities, particularly at the sub-centres, has been voiced by almost all the health functionaries interviewed.

4.6 PERFORMANCE OF DAIS

In this section an attempt has been made to examine the extent of coverage as well as pattern of care provided by both trained and untrained dais:

(a) Cases delivered: The data shows one-third (33.8%) of a total of 130 dais interviewed reported that they had conducted between 1-3 deliveries during a period of three months prior to the date of investigation. The percentage of trained and untrained dais falling in this category works out to be 19.1 and 41.4 respectively. Further, 43.1% of the total (44.4% trained and 41.8% untrained) dais conducted 4 to 6 deliveries during the above reference period. The remaining one-fifth (20.8%) of the dais interviewed reported to have delivered

7 or more babies during the same period and 31.7% of trained and 6.9% of the untrained dais fall into this group. Thus, could be seen that a relatively higher proportion of trained dais fall into groups conducting larger number of deliveries as compared to dais who are untrained. A further break up shows that dais located at PHC and SC villages attended to a relatively larger number of births as compared to those livi in remote villages. However, these differences appear to be only marginal and statistically not significant (Appendix Table 4.11).

Information was also collected regarding number of deli-veries conducted by dais independently and those with the hel of health workers. A little more than one-third (34.6%) of the dais interviews reported that during a reference period o 3 months they had attended to 6 or more child births indepen-dently. The percentage of trained and untrained dais falling in this category works out to be 37.4 and 31.7% respectively. Further 27.6% of the dais (33.4% trained and 22.4% untrained) reported that they had attended to 4-5 deliveries independent Another one-third (34.5%) of the total dais reported that the had independently delivered between 1-3 babies during the reference period of three months; the percentage of trained a untrained dais in this category works out to be 20.7% and 47.8% respectively. Thus, the proportion of trained dais

.....101

conducting larger number of deliveries independently is higher as compared to untrained dais. (Appendix Table 4.12).

As regards number of deliveries conducted independently by dais without the help and assistance of any health functionary according to their location, whether PHC/SC or remote villages, is concerned no clear trend is discernible and the differences do not appear to be statistically significant.

The number of dais who conducted deliveries with the help of ANMs is very small. Out of 130 dais interviewed, 125 (96.1%) reported that they did not conduct any delivery with the help of ANM. Out of 4 dais, who did, 3 are trained and only 1 is untrained. (Appendix Table 4.13).

(b) Ante-natal contacts: Regarding contacts with pregnant women during various stages of pregnancy interviews with the dais reveal that 48 (36.9%) dais did not make any contact with the pregnant women prior to the time of delivery. The percentage of trained and untrained dais not making ante-natal contacts works out to be 20.6 and 52.2 respectively. Thus, proportion of untrained dais not making antenatal contacts with the pregnant women is significantly higher as compared to their trained counterparts. Further, the number of pregnant mothers contacted during different stages of pregnancy by trained dais is significantly more than those of untrained. (Appendix Table 4.14).

2781

.....102

So far as registration of pregnant women at sub-centres or PHCs is concerned, a little more than one-third (35.4%) of the total dais interviewed (33.3% trained and 37.3% untrained) reported that they had not registered any women for antenatal care at the SC or PHC. Another 39.1% (33.3% trained and 44.8% untrained) of dais interviewed reported to have registered 1-3 mothers; and 19.4% of the total dais (26.9% trained and 10.5% untrained) stated that they had registered 3 or more pregnant women at the government facilities for antenatal care. Thus, the proportion of trained dais registering pregnant women at SC/PHC for antenatal care is slightly higher than those of untrained dais though the differences do not appear to be statistically significant. Furthermore, the number of pregnant women registered by trained dais works out to be more than the untrained dais. (Appendix Table 4.15).

With respect to the receipt of tetanus-toxoid by pregnant women, 30% (23.7% trained and 35.8% untrained) dais interviewed reported that no pregnant woman attended by them had received at least two doses of tetanus toxoid. Further 28.5% (30.2% trained and 26.9% untrained) dais reported that 3 or more of the women delivered by them received at least 2 doses of tetanus toxoid works out to be 33.8% for the total group and 38.1 for the trained and 29.9 for the untrained dais. The differences between trained and untrained dais in this regard

.....10

appear to be marginal and there does not appear to be any statistically significant relationship between receipt of tetanus-toxoid by the pregnant women and the training status of the dai. The analysis further shows that the proportion of pregnant women not receiving tetanus toxoid and who were attended by dais living in remote villages is higher than those living in PHC/SC villages. These differences appear to be substantial (Appendix Table 4.16).

Information was also solicited from dais regarding number of pregnant women attended by them who received prophylaxis against nutritional anemia. Normally, prophylaxix against nutritional anemia comprises of administering iron with folic acid starting from third month of pregnancy. The data shows that 30.8% (28.6% trained and 33.3% untrained) dais reported that none of the pregnant women delivered by them had received prophylaxis against nutritional anemia. Further, 43.0% (38.1% trained and 48.5% untrained dais interviewed stated that 1-3 pregnant women attended by them had received this prophylaxis. The percentage of total dais who reported that 4 or more pregnant women delivered by them received prophylaxis comes to 17.6 for the total, 25.5 and 10.6 for the trained and untrained and untrained dais dais respectively. Thus, it could be seen that a higher proportion of mothers attended by trained dais had received prophylaxis against nutritional anemia than those delivered by untrained dais. The data also shows that the

.....104

proportion of women not receiving prophylaxis is significantl higher among those who were attended by dais living in remote areas as compared to those located in PHC/SC villages (Appendix Table 4.17).

(c) Neonatal outcomes: As could be seen from Appendix Table 4.18, 97 (74.6%) dais reported that none of the children delivered by them died. The proportion of trained and untrained dais in this category works out to be 73.0% and 76.1% respectively. Another 13.8% (19.1% trained and 9.1% untrained) reported that one child attended by each of them had died; 3.8% (6.4% trained and 1.5% untrained) reported that two children attended by each had died. Further 2 dais, both untrained, reported the death of 3 children attended by them. Out of 8 still births reported by dais, one occurred when a trained dais was attending and the remaining 7 were reported by untrained dais. (Appendix Table 4.18).

The dais who reported still births or deaths of babies delivered by them were asked about the cause of still birth and death as well as age at death. The cause of still births or deaths reported by 33 dais include breach delivery, fever, tetanus, dehydration, inability to pass urine, prematurity, respiratory trouble, no intake of milk etc. (Appendix Table 4.19). Regarding age at death of infants, 2 trained dais reported that the children died within twenty four hours;

.....105

dais, of whom 6 are trained, reported that the children survived only for a week; 7 dais, of whom 4 were trained, informed that the children died within a period of 4 weeks; and two trained dais reported that the children delivered by them had survived for 3 months (Appendix Table 4.20). Regarding the cause of death of second child attended by dais, 10 dais, of whom 5 were trained, reported still births, 1 untrained dai reported that the child died of thrush, and 2 dais, of whom one was trained, reported premature birth. (Appendix Table 4.21). Regarding age at death of these children, one untrained dai reported that the child died within 24 hours and 2 dais, of whom one was trained, reported that child had died within 7 days. (Appendix Table 4.22). Further, only one trained dai reported that the child had developed septic umbilicus. Regarding number of pregnant women who developed temperature soon after delivery; 9 dais, 5 of whom are trained, reported the same.

(d) Family Planning:

Information obtained from the dais regarding pattern of family planning advise shows that a little more than half (54.6%) advise their clients about the importance and desirability of using family planning methods. A further break up of data according to the training status of dais show that the proportion of trained dais advising family planning is overwhelmingly high (82.5%) than that of untrained dais (28.4%).

.....106

Among 58 (44.6%) dais who reported that they were not advising family planning to their clients, 48 are untrained. So far as family planning advise according to the location of the dai is concerned, analysis reveals that 60.0% of the dais located at PHC/SC villages were rendering family planning advise against 45% of dais located in remote villages. (Appendix Table 4.23). The dais who reported that they were advising family planning were also asked about the reasons for doing so. An overwhelming majority of dais failed to specify the reasons and a few mentioned avoidance of unwanted births as the major reason (Appendix Table 4.24). With respect to reasons for not advising family planning; 23 dais, of whom 4 are trained, reported that they did not have any knowledge of family planning methods; 5 dais, of whom 2 are trained, reported that no one in the community is prepared to listen to them on these matters. 14 dais, 1 trained and 13 untrained, reported that it was not their job to advise family planning. The data, by and large, shows that the untrained dais do not show sufficient interest in family planning. (Appendix Table 4.25).

(e) Number of cases motivated for family planning by dais:

Information collected about number of cases motivated for family planning shows that the trained dais motivated a significantly larger number of cases as compared to untrained dais. Further breakup according to methods of family planning shows that dais motivated mainly for sterilization. The advise

bout Nirodh was reported to be given by 10 dais, all of whom, re trained. The other methods of family planning were less opular among them.

.7 Quality of Dai Services

a) Overall advice pattern:

Information regarding general pattern of advice given by dais with respect to various antenatal aspects was obtained through interviews with the dais and the women attended by them. n attempt has been made in the following paragraphs to high- light the major findings.

Approximately one-third (30.8%) of a total of 130 dais interviewed reported that they advise pregnant women to regis- ter themselves at sub-centres for antenatal care. A further break up of respondents according to their training status reveals that while 47.6 of the trained dais are reported to be rendering such advice; the corresponding percentage for the untrained dais works out to be only 14.9. Further, a little more than two-thirds (43.8%) of the dais interviewed stated that they advise pregnant women for regular check up at the sub-centre or PHC. Hereagain, the percentage of trained dais (65.1%) is significantly higher than that of untrained dais (23.9%). As regards advising pregnant women for tetanus- toxoid, 43.8% (66.7% trained and 17.9 untrained) of dais

.....108

interviewed reported that they have been giving this advice to the women. About one-fifth (19.2%) of the total dais interviewed informed that they advise pregnant women about proper nutrition. In this regard 28.6% of the trained and 10.4% of the untrained dais reported to be giving such advise. Again 20.0% (25.4% trained, and 14.9% untrained) mentioned that they advise the pregnant women how to prepare for hom confinement. So far as prophylaxis against nutritional anemia is concerned, 31.5% (49.2% trained and 14.9 untrained) are reported to be advising pregnant women about it. One-fifth (20.0%) of the dais reported that they advise women about various methods of family planning. A further break up of these dais according to their training status reveals that percentage of trained dais giving family planning advice is substantially higher when compared to untrained dais 34.(% as against 8.0%. Approximately one-sixth (15.4%) of the dais maintained that they advise pregnant women about personal hygiene. The percentage of trained and untrained dais giving this advice works out to be 23.8 and 7.5 respectively.

A further break up of pattern of advice given by dais according to their location shows that a significantly higher proportion of dais living in the PHC/SC villages claimed to have been giving advice on various antenatal matters as compared to dais residing in remote villages. (Appendix Table 4.27).

It is thus clear from the responses of dais that a significantly larger proportion of trained as against untrained dais have been rendering advice to the pregnant women about different antenatal aspects and family planning.

Information was also obtained from the women delivered by dais about the type of advice received by them from the dais during their respective pregnancies. This was done to cross check the data gathered from the dais. The women were asked to give information about the type of advice received by them with respect to last two pregnancies. Regarding latest pregnancy out of 698 women who responded, 198 (28.4%) reported that the dai had advised them for tetanus toxoid injection. A further break up according to training status of dais who attended on them reveals that while 46.3% of the women attended by trained dais received this advice, the percentage of women attended by untrained dais in this regard works out to be only 11.8. Regarding prophylaxis against nutritional anemia 27.6% (47.2% attended by trained and 11.0% by untrained dais) of the women interviewed reported that they received this advice from dais during their last pregnancies. Another 40.1% of the women (53.6% attended by trained and 27.0% by untrained dais) informed that the dais had advised them about necessary preparations for home confinements. Regarding regular check-up during various stages of pregnancy, 23.1% (36.1% attended by trained

.....110

and 10.4% by untrained dais) reported to have been advised about it by their respective dais. (Appendix Table 4.28).

Regarding type of advice given by dais to the pregnant women during earlier pregnancy, many women did not have earlier pregnancy and some could not respond due to memory lapses. The analysis therefore is based on responses obtained from 189 women.

Out of 189 women interviewed 31 (15.6%) reported that dai had adviced for tetanus toxoid. A further break up according to the training status of dais reveals that while 29.4% of the women attended by trained dais received this advice, the percentage for those attended by untrained dai works out to be 5.8 only. With regard to prophylaxis against nutritional anemia 26 (16.8%) women reported to have received this advice. Hereagain, the percentage of women attended by trained dais (25.9%) far exceeds than those attended by untrained dais (3.9%). Approximately one-fourth (25.4%) of the women reported that they were advised by their respective dais regarding preparation for home confinement. This advice is reported to have been received by 36.5% and 16.3% of the women delivered by trained and untrained dais respectively. A little less than one-tenth (9.0%) of the women stated that the dai advised them for regular check up during the ante-natal period at the SC/PHC. A further break up of these responses according to

the training status of the dai shows that while 14.1% of the women delivered by trained dais received advice for regular check up as against only 4.8% by those delivered by untrained dais (Appendix Table 4.28).

The above analysis clearly indicates that the pattern of advice received by the women during their earlier pregnancies is the similar to that of latest pregnancies. Furthermore, significantly higher proportion of women attended by trained dais are reported to have received different types of ante-natal advice as compared to those attended by untrained dais.

Information was also solicited from the women interviewed about the number of visits made by the dais to their respective homes during their latest and earlier pregnancies. An overwhelming majority (92.8%) of the women reported that during their latest pregnancies the dais who delivered their babies did not visit them during antenatal period. Further 6.3% of the women reported that the dai visited them only once and the proportion of women reporting more than one visit is negligible. A further break up of respondents according to the training status of dais who delivered their babies reveals that while 9.6% of the women attended by trained dais reported at least one visit, the corresponding percentage for those delivered by untrained dais is only 5.4.

.....112

As regards dai's visits to homes of pregnant women during earlier pregnancy, out of 189 women reporting earlier pregnancies 160 (84.7%) stated that the dais did not make any visit. Only 8 women (5 attended by trained dais and 3 by untrained dais) reported that the dai had visited their homes atleast once. (Appendix Table 4.29).

(b) Problems during pregnancy and action taken by dai

All the women interviewed were asked to list the problems and complications encountered by them during their latest as well as earlier pregnancies and the action taken by their respective dais to alleviate those problems and complications. The analysis here is confined to three main problems i.e. (i) swelling of feet, (ii) bleeding, and (iii) repeated attacks of pain. An overwhelming majority (92.3%) of the women interviewed reported that they did not face any problem during their latest pregnancies. Only 6.8 percent (7.3% attended by trained dais and 6.5% by untrained dais) reported some problems. Out of these 48 women 30 (62.5%) reported oedema of feet, 12 (25.0%) mentioned repeated attacks of pain, 1 (2.1%) bleeding, and the remaining 5 (10.4%) oedema with repeated attacks of pain. No significant differences have been found in the reporting of problems by women attended by trained and untrained dais.

.....113

The reporting of problems during earlier pregnancies is negligible. Only one woman, attended by trained dai reported oedema of feet and another attended by untrained dai reported bleeding (Appendix Table 4.30).

Action taken by dais with regard to the problems faced by pregnant women is an important index of the quality of ante-natal care provided by dais. Out of 30 women reporting oedema of feet during their latest pregnancies, 12 reported that they did not contact any dai for advice or treatment. Another 12 women who consulted dai for this problem were unable to specify the action taken by dai. Out of the remaining 6 women 3 (2 attended by trained and 1 by untrained dai) reported that they were advised to consult private practitioners and other 3 (1 attended by trained and 2 by untrained dais) reported that they were referred to the sub-centre. One mother who was attended by trained dai and reported oedema of feet during previous pregnancy could not specify the action taken by the dai. As regards action taken by dais for bleeding and repeated attacks of pain, none of the women who reported these problems was able to specify the type of action taken by dai. (Appendix Table 4.31).

.....114

(c) Natal care and advice:

Information collected from women deliverer with regard to natal practices of dais include: time spent before, during and after delivery; assistance of health functionaries during delivery, use of maternity kit, sterilization of instruments etc. The detailed findings on these aspects are given below:

Regarding presence of dai before delivery, a little more than half (56.9%) of the women interviewed reported that during their latest pregnancies, the dai arrived more than one hour before actual delivery; another 27.4% mentioned that the dai was present about half an hour before the delivery; 4.4% stated that the dai arrived just before the delivery. The remaining 11.0% reported that dai came after the child had been delivered. With respect to the previous delivery approximately one-fourth (23.8%) could not specify the time of dai's arrival, a little less than half (48.7%) reported that the dai came more than one hour before delivery; another 18.0% mentioned that the dai arrive approximately half an hour before the baby was actually delivered; 1.6 reported that the dai came just before the actual delivery. The remaining 7.9% of the women reported that during their earlier delivery the dai arrived at the place of confinement after the child had been delivered. No significant difierences have been observed with regard to dais presence before delivery at the place

of confinement and her training status whether trained and untrained (Appendix Table 4.32).

The women were also asked whether the dai was accompanied by any health worker when she came to deliver the child. An overwhelming majority (97.7%) of the women interviewed gave negative replies to this question. Out of 12 women reporting accompaniment of health workers during their latest confinement, 11 were delivered by trained dais. With respect to previous pregnancy only one woman attended by trained dai reported that the dai was accompanied by a health worker. (Appendix Table 4.33).

Further 115 (16.5%) women, all delivered by trained dais, reported that the dai had brought the maternity kit when she came to deliver the child. This accounts for only one-third (33.5%) of the women delivered by trained dais. The indicates that two-thirds of the trained dais had not taken their delivery kits at the place of confinement. This may be due to the reasons that the maternity kits are not issued and replenished or the dais are not very keen on using them.

So far as other hygienic practices of conducting delivery are concerned, 552 (79.1%) of the women reported that the dai had washed her hands before delivering the child. A break up of respondents according to the training status

.....116

of the dais who attended on them do not bring out any statistically significant difference between these two groups. Approximately four-fifth (39.5%) of the women indicated that the dai had boiled the equipments before use. Here the differences between two groups of women-one attended by trained and the other by untrained-are substantial (56.3% as against 23.4%). As regards giving of some drink before delivery 70.3% (72.9% attended by trained and 67.9% by untrained dais) reported that the dai had given them some drink to facilitate the process of delivery. An overwhelming majority (96.8%) reported that the dai comforted them before delivery and the differences between the responses of those attended by trained and those by untrained dais are negligible. A little more than one-third (36.5%) of the women mentioned that the dai had pressed hand on their abdoman to quicken the delivery and expulsion of placenta. Here too, the differences in responses are not very marked (40.2% for the women delivered by trained dais as against 33.0% for those whose latest child was delivered by untrained dai). Only 19 women reported that the dais administered some drugs before delivery and 13 of those were attended by trained dais. (Appendix Table 4.34).

It is thus clear from the above analysis that except boiling of equipment and administration of drungs no significant difference has been observed between the natal practices of trained and untrained dais as reported by the women delivered by them.

.....117

Similar pattern has been observed with regard to earlier pregnancy. (Appendix Table 4.35).

The major instruments used by dais for cutting the cord, as reported by the women delivered, are scissors, blade, sickle and knife. With respect to the latest pregnancy scissors were reported by 25.6% (46.4% by women attended by trained and 5.6 by untrained dais), blade was mentioned by 62.3% (45.2% delivered by trained and 78.9% by untrained dais). The sickle and knife were reported only by 8.2% and 2.1% of the women respectively. So far as earlier pregnancy is concerned the scissors, as an instrument for cutting the cord, has been mentioned only by a few respondents (4.8%), otherwise pattern is similar.

The findings reveal that a relatively larger number of trained dais have used scissors for cutting the cord, while a great majority of the untrained dais, as reported by the women delivered, have used blades. The other two instruments i.e. sickle and knife are reported to have been used only by a few dais. (Appendix Table 4.36).

So far as boiling of these instruments is concerned about two-fifths (39.5%) of the women interviewed reported that the dai had boiled the instruments used for cutting the cord during their latest pregnancy. A break up of these responses according to the training status of the dais who

.....118

delivered their children reveals that while 56.6% of the women attended by trained dais reported boiling of instruments, the corresponding percentage for those attended by untrained dais works out to be 23.1. Regarding earlier pregnancy only 18% (24.7% and 12.5% attended by trained and untrained dais respectively) reported boiling of instruments by dais. Further, with regard to the use of rubber sheet for deliver, only 11.9% (22.7% attended by trained dais and 1.4% by untrained dais) of the women reported that the dai used the same at the time of conducting delivery. For earlier delivery only 4 women, 3 delivered by trained and 1 by untrained dai, reported that rubber sheet was used. Thus the use of rubber sheet was primarily limited to trained dais. Further, most of the women reported that the dais had kept old clothes ready for use during the delivery and in this respect no differences have been observed in the responses of these two groups of women- one attended by trained and the other by untrained dais. (Appendix Table 4.37).

Information was also collected regarding time spent by dai during delivery. With respect to their latest pregnancy, 70.8% of the women reported that the dai spent between 1-2 hours. Another 19.3% stated that the time spent by dai ranged between 2 and 3 hours. As regards earlier pregnancy approximately one-fifth of the respondents could not specify the

.....119

time, a little more four-fifths (43.4%) reported 1-2 hours while 21.7 stated that during their earlier pregnancy the dai spent from 2 to 3 hours. The number of dais reporting less than 1 hour and more than 3 hours, both during the latest and earlier pregnancy, is very small. Further, no significant differencials have been observed in the reported time spent by the dai during the delivery according to the training status of dai. (Appendix Table 4.38).

(d) Post-natal care and advice:

The post-natal complications reported by the women, both during their latest and earlier pregnancies are negligible. A very small number of women reported fever and post-partum haemorrhage and the differentials in the responses of those delivered by trained and untrained dais are not very marked. (Appendix Table 4.39).

So far as action taken by the dai for complications during pregnancy is concerned, in majority of the cases the women delivered did not report the problem to the dai. Whenever the dai's advice was sought for fever and post-partum haemorrhage the dai either took no action or referred the woman to the private medical practitioners. The number of cases in which the help of a health worker was sought or the patient was referred to the government health facility

are very few. Further, no significant differentials have been observed in the type of action taken by the dais for complications according to their training status. (Appendix Table 4.40).

Information was solicited from dais about the duration of follow up of mothers after the delivery. The data shows that a great majority of dais (71.5%) provided post-natal care to the mothers for more than 7 days after the delivery. A further break up of these dais shows that 79.4% of the trained dais fall into this category while the percentage of untrained dais works out to be 64.2. Further 19.2% (15.9% trained and 22.4% untrained) dais followed up the mothers for a period of 4 to 6 days. Another 8.5% (4.8% trained and 12.0% untrained) dais provided 1 to 3 days follow up. The above data thus indicates that the trained dais followed up the mothers for slightly longer period as compared to the untrained dais but the differences are only marginal and do not appear to be statistically significant. (Appendix Table 4.41).

Regarding follow up care of new born babies, it is difficult to separate the follow up of mothers from the new born. In fact during their post natal visits the dais provide required care to both mothers and the babies. As expected, a pattern similar to those of following up mothers has been observed in case of new born babies. Here again, the

.....121

differentials between trained and untrained dais are not significant. (Appendix Table 4.42).

So far as specific care provided to the mothers during post-natal period is concerned a little more than half (53.8%) of the dais interviewed reported that they provided care for the control of bleeding. The other important services reported to have been provided in order of their numerical importance are: general health check up (50.0%), oil massage (30.8%), water bath (30.0%), care of the breast (29.2%), care of abdomen (21.5%).

There are no significant differentials in the type of services provided to the mothers during the post-natal period by trained and untrained dais.(Appendix Table 4.43).

The major services provided to new born, as reported by the dais, in order of their numerical importance are: general health check up (51.5%), care or cord (46.2%), hot bath (36.1%), oil massage (24.0%). Here again, no substantial differentials have been observed in the type of services provided for the care of new born according to the training status of dais. (Appendix Table 4.44).

.....122

A question was asked from the women delivered to ascertain their satisfaction from the services provided by the dais. The responses show that 99.4% of the 698 women interviewed indicated their satisfaction. (Appendix Table 4.45).

A further question was asked to find out the reasons for their expressed satisfaction. A little more than half (51.3%) the respondents stated that easy accessibility was an important reason for their satisfaction. The other major reasons mentioned were: proper and efficient execution of delivery (22.2%), overall skill and efficiency (18.2%). The reasons for satisfaction indicated by the women attended by trained and untrained dais are almost same and no significant differentials have been observed in this connection. (Appendix Table 4.46).

It is thus clear from the above that client satisfaction with dai services is not based on her training status.

CHAPTER 5

Dai in relation to community and health functionaries

CHAPTER 5

DAI IN RELATION TO COMMUNITY AND HEALTH FUNCTIONARIES

In this Chapter, we present the pattern of relationships between the dai on the one hand, and communities they serve and health-workers at various levels on the other.

5.1 Remuneration for dai services

Our interviews with women delivered by dais, by and large, reveal that the dais are well acquainted with the communities in which they operate. Out of 698 women interviewed, 456 (65.3%) reported that they knew the dai for more than seven years. Another 25.4% stated that the dai is known to them for more than four years but less than seven years. Further, less than one-tenth (9.3%) of the respondents reported that they knew the dais for three or lesser number of years.

A break up of these respondents according to the training status of the dais who attended on them do not reveal any significant relationship between duration of mothers' acquaintance with the dais and the training status of the latter - whether trained or untrained (Appendix Table 5.1).

.....121

The women attended by dais were asked to indicate the amount paid in cash and kind for the services of dai, both during the latest and earlier delivery. Regarding latest delivery, a little more than half (54.9%) the women interviewed indicated that nothing was paid in cash to the dai. Another 8.9% reported to have paid between Rs.1-2, 11.3% between Rs.3-5, and the payment in cash made by 12.9% ranged between Rs.6 and Rs.10. The percentage of women who reported to have paid more than Rs.10/- as cash remuneration to dai is very small (11.8). The amount of payment in cash reported to have been made by women for the services provided during their latest delivery to trained and untrained dais do not differ significantly. (Appendix Table 5.2).

With respect to the earlier delivery, 50.8% (45.9% delivered by trained and 54.8% by untrained dais respectively) paid between Rs.1-2, 8.5 (14.1% and 3.8% attended by trained and untrained dais) paid cash ranging between Rs.3 and Rs.5. 11.1% (8.2% and 13.5% delivered by trained and untrained dais) reported to have paid between Rs.6 and Rs.10. Another 11.1% (6.0% and 15.3% delivered by trained and untrained dais respectively) indicated that cash amount paid by them to dais for the services provided during earlier delivery was more than Rs.10. Thus, for earlier delivery the amount paid in cash to trained dais has been found to be slightly more than the

.....125

untrained dais (Appendix Table 5.3). However, it would not be safe to conclude from this data that trained are paid more than untrained dais because the number of responses for earlier deliveries are relatively fewer and there may be reporting errors due to memory lapses.

Remuneration paid to dai in kind include items like clothes, food grains, ornaments etc. Our interviews with mothers reveal that during their latest delivery, 44.8% (48.1 attended by trained and 41.7% by untrained dais) of the women did not give anything in kind, 20.9% (22.2% and 19.7% delivered by trained and untrained dais respectively) gave food grains, and 17.2% (14.0% and 20.3% attended by trained or untrained dais respectively) reported to have given ornaments. The number of respondents who mentioned other kinds of payment is very small (Appendix Table 5.4).

The pattern of payment reported in case of earlier delivery is not markedly different than the latest delivery. (Appendix Table 5.5).

5.2 Contact with Health Functionaries:

So far as contacts with health workers at various levels are concerned, out of 130 dais interviewed, 40 (30.8%) reported that they do not have any contact with health workers in their respective areas of operation. The percentage of trained and

.....126

untrained dais in this category works out to be 7.9 and 52.2 respectively. Another 53.1% (68.2% trained and 38.8% untrained) indicated that have contacts with the HW (F)/ANMs. Further, 12.3% (16.9 trained or 9.0 untrained) reported to have contacts with HA (F)/LHVs. It is thus clear from the above that proportion of trained dais having contacts with government health functionaries is substantially higher as compared to untrained dais. Our data also shows that dais living in remote villages have far lesser contacts with health workers as compared to those living in PHC/SC villages (Appendix Table 5.6).

As regards purpose of contact, multiple responses elicited from the dais indicate that, by and large, dais contact health workers for managing difficult labour (20.8%), reporting of births or deaths (16.2%), registration of antenatal or post-natal cases (15.4%), immunization of babies (9.2%), general check up of women delivered (8.5%), family planning (6.1%) etc. The proportion of trained dais making contacts for each of the above reasons is significantly higher than the untrained dais. (Appendix Table 5.7).

5.3 Type of help rendered to health functionaries

Information was also solicited with regard to the type of help rendered by dai to the health workers. The data reveals that 44.6% (27.0% trained and 61.2% untrained) of the

....127

dais interviewed did not in any way help the health workers, 44.6% (33.3% trained or 13.4% untrained) helped the workers in the registration of pregnant women for antenatal care, 18.5% (27.0% trained and 10.4% untrained) assisted in the immunization camps, 16.9% (23.8% trained or 10.4% untrained) help the health workers in conducting deliveries, 13.1% (17.8% trained and 9.0% untrained) helped in the registration of births and deaths, and 10.0% (17.5% trained and 3.0% untrained) assisted the various categories of health functionaries whenever family planning camps were organised in their respective areas. The other assistance reported was distribution of IFS tablets (5.4%), provision of post-natal care to mothers (1.5%).

5.4 Willingness to work with health functionaries:

The dais were also asked whether they would like to work with the health workers. The responses show that a little more than one-third (36.2%) of the dais expressed their willingness to be associated with the health workers, and 46.4% reported that they would not like to work with them and the remaining 18.4% could not give specific answers. A further break up of these responses according to the training status of the respondents reveal that the proportion of untrained dais who expressed their willingness to be associated with the health workers is almost negligible.(Appendix Table 5.9).

The dais who reported that they do not want to work with the health workers were asked to specify the reasons for the same. Most of them indicated that they are unable to work with the health workers due to domestic problems. (Appendix Table 5.11).

5.5 Payment of Stipend

Almost all the trained dais reported that they had received stipend money ranging between Rs.250/- and Rs.300/- for training. However, responses with regard to the time receipt of payment vary. A little more than one-third (36.5%) of the dais interviewed indicated that they received their stipend three months after the training. Approximately two-fifths (41.3%) after a month, and the remaining one-fifths (20.7%) within a month after the completion of training. (Appendix Table 5.12).

Regarding payment of remuneration for registration of pregnant women for antenatal care, nearly three fourth (73.0%) of the trainers interviewed reported that they had not received any such remuneration. The percentage of those reporting a payment of Rs.2.0, Rs.3.0 and Rs.4.0 works out to be 15.9, 7.9 and 1.6 respectively. (Appendix Table 5.13).

.....129

5.6 Continuing education of dais

All the trained dais interviewed were asked to make suggestion for improvement which could be made in the existing dai training programme. In this connection a little more than two-fifths (42.8%) of the dais reported that they did not have any suggestions to make. The suggestions preferred by others are: provision for full time employment to trained dais (31.7%), teaching of latest techniques of midwifery (9.5%), timely distribution of stipend and kits (6.5%), increase in the length of training period (4.8%), more emphasis on techniques to handle complicated cases (3.1%), proper follow up by health workers (3.1%), and increase in stipend. (Appendix Table 5.14).

Approximately half (50.8%) of the trained dais indicated that they need further training as the training already imparted to them is not sufficient. They were further asked to specify the duration of retraining which they feel would be adequate. Most of these interested in retraining mentioned that 3 to 4 weeks would be enough. (Appendix Table 5.15).

All these dais who indicated the need for retraining were asked to specify the topics which they would like to be included in such a programme. The most important aspects which the dais wanted to be emphasised in the retraining wa management of difficult labour. A large proportion of the

.....130

dais also expressed the opinion that the present curriculam should be repeated during the retraining. (Appendix Table 5.16).

The opinions of the trainers were also solicited with regard to retraining of dais. Out of 14 trainers interviewed, 11 opined that there is a definite need for periodical retraining. When asked about the appropriate time for such training, 5 of them could not provide specific answers, 4 reported that it should take place one year after initial training, 1 trainer each mentioned that the retraining should be conducted after 2 and 3 years respectively. (Appendix Table 5.18).

Regarding place of retraining, 9 trainers expressed the view that it should be conducted at PHC headquarters, and 1 stated it would be more appropriate to locate it in dai's village (Appendix Table 5.19). With respect to the topics for retraining, a great majority of those who were in favour of retraining pointed out that management of normal delivery should be emphasised (Appendix Table 5.20). So far as duration of retraining is concerned, 5 trainers thought it should be between 8-15 days while another 3 favoured 23-30 days. One trainer each expressed the view that the duration of retraining should be 1-7 days and 2-3 months respectively (Appendix Table 5.22).

When asked if a retraining program has ever been carried out in their area, 12 out of 14 trainers interviewed replied in the negative (Appendix Table 5.22).

CHAPTER 6

Summary and conclusions

CHAPTER 6

SUMMARY AND CONCLUSIONS

Inspite of greater expansion of medical and health services in India during the post-independence period, an overwhelming majority of our people, particularly those living in the rural areas, continue to seek medical care from indigenous sources of medical care. It is now very clear that our goal of 'Health For All by 2000 AD' cannot be achieved if we have to depend only on governmental sources to accomplish this objective. There is an urgent need to fully exploit the local sources, as recommended by many national and international committee for the benefit of the community. The traditional birth attendants who attend to a large proportion of births in the rural areas and provide other needed services to women and children, are an important such resource. The available literature on TBAs shows that many of their practices are harmless and provide psychological and emotional support to the mother and the family. However, there are certain practices which are harmful to the mother and child and probably contribute to high infant and maternal mortality Before they are incorporated into the village based primary health care programmes, there is a need to improve their practices through proper training and follow up supervision. This will greatly facilitate the integration of their services with the existing health care system. Many training programmes have been organized in various parts of the world,

.....132

as the review included in the Chapter I would show, to improve their skills and practices. In fact India was the first country among the developing nations to take cognisance of their role and initiate various TBA training programmes since the advent of development plans, more particularly from the Second Five Year Plan. The principal aim of these training programmes has been to help TBAs to conduct deliveries in aseptic and hygienic manner and bring them into linkages with Maternal and Child Health (MCH) services, including family planning rendered through primary health centres (PHCs) complex. The TBA training programme has recently received a great stimulus and during the Sixth Five Year Plan (1978-83), it is envisaged to provide one trained dai for every village. In order to find the effectiveness of this training programme, in terms of the objectives laid down, an evaluation of the training scheme was carried out in the state of Maharashtra at the instance of the Government of India, Ministry of Health and Family Welfare. The detailed results of this evaluation are given in the body of this report. The major findings are summarized below:

1. For the purpose of this evaluation, three districts, representing various regions of Maharashtra were selected. From each district 4 Primary Health Centres (PHCs) were randomly chosen. The villages comprising a PHC were further stratified according to a set criteria given in Chapter I, and six trained

dais were selected for interviews. Further 5 women delivered by each of these dais were also interviewed. Thus, this evaluation is based on interviews with 130 dais (63 trained and 67 untrained) and 698 women attended by them. In addition, interviews were also carried out with various categories of health functionaries at the sub-centre, primary health centre and district levels.

2. An overwhelming majority (68.5%) of dais are 45 years of age. The proportion of those in younger age groups has been found to be higher among trained dais.

3. Almost all the dais are 'once married' but approximately half are 'currently married' while the others are widows.

4. A very large percentage (95%) of dais have more than three living children and the untrained dais have more living children as compared to their trained counterparts.

5. All except 5 dais belong to Hindu religion. Further, approximately one-half of the dais interviewed are scheduled castes/tribes and the remaining half are equally distributed among 'middle' and 'higher' caste group. The dai's caste has not been found to be significantly related to her training status.

.....134

6. Out of 130 dais interviewed, 124 reported that they are illiterates, and out of the remaining six reporting some schooling, 4 are trained and 2 untrained.

7. A little more than three-fifths (61.5%) of dais reported that attending to births was their hereditary profession, and trained and untrained dais are almost equally distributed in this category.

8. For three-fourths (75.4%) of the dais interviewed attending to births was the primary occupation, while for the others it was only a secondary occupation.

9. The reported monthly family income of 30.0% of the dais is less than Rs.100 and for another 46.1% it ranged between Rs.100 and Rs.199. The family income of remaining one-fourths of the dais is reported to be more than Rs.200 per month. There is no significant relationship between dai's family income and her training status.

10. Approximately one-half the dais interviewed had more than 15 years experience of attending to births. There does not appear to be any significant relationship between number of years of experience and training status of dais.

.....135

11. A little more than half (56.6%) of the dais came to know about the Dai Training Programme through the health functionaries. Another major source of information reported was community leaders which was mentioned by approximately one-third (30.2%) of the dais who had already undergone training.

12. The health functionaries were the major motivating force for dais to undergo training. The role of community in this respect has been found to be limited.

13. Regarding criteria for selection of trainees, dai's residence in the village, her interest in improving her performance as a dai, competence and popularity were some of the considerations for enlisting the dais for training. The recommendations from the health functionaries and community leaders are also reported to have been given due consideration. There has not been any systematic effort on the part of the PHCs to prepare a list of dais in their respective areas. The PHCs only maintain a list of trained dais.

14. Out of 12 PHCs in three districts of Maharashtra, only in one PHC the dai training programme is reported to have been conducted at the sub-centre level. In the remaining PHCs the training programme had been carried out at the PHC headquarter only.

.....136

15. The training was primarily given by HW (F)/ANMs under the supervision of HA (F)/LHVs with occasional inputs from the medical officers. An overwhelming majority (71.4%) of the trainers had professional experience ranging between 1 to 4 years.

16. The information obtained from trainers reveal that a large proportion of the training time was spent on field activities, both supervised and unsupervised. The class room and clinical demonstrations were reported to have been carried out only at the PHC headquarters.

17. The methods of teaching reportedly employed by the trainers included lectures, discussion, demonstration, role play and observational visits. However, emphasis laid on a particular method of training varied from trainer to trainer.

18. The training facilities, both at the Primary Health Centres and sub-centres, are reported to be inadequate. The situation is particularly bad at the subcentres where even the basic equipments required for training are not available.

19. There is no systematic method of evaluating the trainees after the training. It is only done through oral tests which vary from trainer to trainer.

.....137

20. The delay in payment of stipend money has been reported by a majority of trained dais and health functionaries. Further most of the dais complained of non-payment of remuneration for registering pregnant women for antenatal care. Administrative and communication problems are the reasons given by medical officers for these lapses.

21. The community participation in the training programme is reported to be minimal. There has been no effort on the part of health functionaries at various levels to publicise the training programme and educate the community about its usefulness.

22. There has been no systematic effort to effectively monitor the training programme. This is reported to be due to excessive workload and competing demands on the time of various categories of health functionaries.

23. There is a considerable delay in the distribution of kits to dais and these are rarely replenished. Moreover, an overwhelming majority of dai's do not carry the kit when they go for conducting deliveries.

24. A significantly higher proportion of trained dais, as compared to untrained dais, report to have contacts with various health functionaries, especially ANMs.

25. Most of the trained dais expressed their willingness to associate with the health functionaries in the provision of various kinds of health services to the community. The number of untrained dais volunteering to provide such services is very small.

26. The antenatal service provided by trained dais have been reported to be much wider than those by untrained dais. Further trained dais appear to manage antenatal complications better than their untrained counterparts.

27. A significantly higher proportion of the trained dais are reported to have conducted deliveries in aseptic and hygienic manner as compared to untrained dais.

28. The proportion of trained dais rendering family planning advice is substantially higher when compared to untrained dais. Further, trained dais motivated a significantly larger number of cases for family planning than untrained dais.

.....139

29. The remuneration for dai's services by the community is through cash and kind. By and large, payments were made in combination of both cash and kind. The kind payments included clothes, foodgrains, ornaments utensils etc. The payments made to trained dais as well as untrained dais are not significantly different.

30. Almost all the trained dais felt that the training programme was helpful to them and a large proportion of them felt a need for retraining in order to improve their professional skills.

APPENDIX TABLES

Appendix Table 3.1

Marital Status of Trainers according to location

Marital Status	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Unmarried	5	38.5	-	-	5	35.7
Married	7	53.8	1	100.0	8	57.1
Widowed	1	7.7	-	-	1	7.1
Total	13	100.0	1	100.0	14	100.0

Appendix Table 3.2

Educational status of trainers according to location

Educational status	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Middle	4	30.8	1	100.0	5	35.7
High school	3	23.1	-	-	3	21.4
Higher secondary	6	46.2	-	-	6	42.9
Total	13	100.0	1	100.0	14	100.0

....141

Appendix Table 3.3

Total experience of trainers according to location

Experience in years	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
1 - 2	6	46.2	-	-	6	42.9
3 - 4	3	23.1	1	100.0	4	28.6
5 - 6	1	7.7	-	-	1	7.1
7 - 8	1	7.7	-	-	1	7.1
Can't say	2	15.4	-	-	2	14.3
Total	13	100.0	1	100.0	14	100.0

Appendix Table 3.4

Number of batches trained as reported by trainers according to location

No. of Batches	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Two	3	23.1	-	-	3	21.4
Three	1	7.7	-	-	1	7.1
Four	3	23.1	-	-	3	21.4
Five	2	15.4	-	-	2	14.3
Six	1	7.7	-	-	1	7.1
Seven +	2	15.4	1	100.0	3	21.4
Can't say	1	7.7	-	-	1	7.1
Total	13	100.0	1	100.0	14	100.0

...142

Appendix Table 3.5

Total No. of Dais trained as reported by trainers according to location

No. of Dais trained	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
11 - 15	2	15.4	-	-	2	14.3
16 - 20	2	15.4	-	-	2	14.3
26 - 30	2	15.4	-	-	2	14.3
36 - 40	-	-	1	100.0	1	7.1
41 - 45	1	7.7	-	-	1	7.1
46 - 50	1	7.7	-	-	1	7.1
51 - 55	2	15.4	-	-	2	14.3
56 - 60	1	7.7	-	-	1	7.1
Can't say	2	15.4	-	-	2	14.3
Total	13	100.0	1	100.0	14	100.0

Appendix Table 3.6

Source of information regarding training programme as reported by trained dais according to location

Source of information	PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%
Trained dai	3	7.1	1	4.8	4	6.4
Untrained dai	1	2.4	-	-	1	1.6
HW(F)/ANM	16	38.1	5	23.8	21	33.3
Other health staff	10	23.8	6	28.6	16	25.4
Community leaders	11	26.2	8	38.1	19	30.2
Relations/Friends	1	2.4	-	-	1	1.6
Can't say	-	-	1	4.8	1	1.6
Total	42	100.0	21	100.0	63	100.0

....144

Appendix Table 3.7

Source of motivation for dais to undergo training according to their location

Source of motivation	PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%
Trained dai	3	7.1	-	-	3	4.8
HW(F)/ANM	21	50.0	10	47.6	31	49.2
Other health staff	6	14.3	2	9.5	8	12.7
Community	13	31.0	9	42.9	22	34.9
Self	1	2.4	-	-	1	1.6

*Positive responses only

Appendix Table 3.8

Considerations for selecting dais for training as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Belongs to village which has no dai	13	100.0	-	-	13	92.9
Belongs to Remote area	12	92.3	-	-	12	85.7
Interested in improving dais work	13	100.0	1	100.0	14	100.0
Compe tent & Popular	9	69.2	1	100.0	10	71.4
Supported by pressure groups	3	23.1	-	-	3	21.4
Suggested by health staff	5	38.5	-	-	5	35.7
Personal attachment	4	30.8	-	-	4	28.6
Needy women of the area	12	92.3	-	-	12	85.7
Others	11	78.6	1	100.0	12	85.7

Note:- Multiple responses

Appendix Table 3.9

Odd beliefs and practices of dais as perceived by trainers according to location(Ante-natal)

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Advise to keep busy in domestic work	1	7.7	-	-	1	7.1
Advise no rest during noon hours	6	46.2	1	100.0	7	50.0
Others	10	76.9	1	100.0	11	78.6

*Multiple response

Appendix Table 3.9a

Odd beliefs and practices of dais as perceived by trainers according to location(Intra-natal)

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Deliver in cow shed/ no botheration about place of delivery	9	69.3	-	-	9	64.3
Ill ventilated and un-tidy dark room to avoid air to get in	11	84.7	1	100.0	12	85.7
Others	2	15.4	1	100.0	3	21.4

*Multiple response

Appendix Table 3.9b

Odd beliefs and practices of dais as perceived by trainers according to location(Post-natal)

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Use of blade/sickle/ stone etc/unsterilized instrument	9	69.2	1	100.0	10	71.4
Dressing of cord with anything available (ash,ghee,oil etc)	3	23.1	-	-	3	21.4
Cord cut when placenta has just come out	1	7.7	-	-	1	7.1
Administer castor oil to baby	1	7.7	-	-	1	7.1
Advise not to give first day's milk	6	46.2	1	100.0	7	50.0
Irregular bath/oil massage	2	15.4	-	-	2	14.3

*Multiple response

Appendix Table 3.9c

Odd beliefs and practices of dais as perceived by trainers according to location(Immunization)

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Immunization of children & mothers considered useless	5	38.5	1	100.0	6	42.9
Immunization considered dangerous	6	46.2	-	-	6	42.9
Immunization considered responsible for foetal death	6	46.2	-	-	6	42.9
Others	3	23.1	-	-	3	21.4

*Multiple response

Appendix Table 3.9d

Odd beliefs and practices of dais as perceived by trainers according to location(Prophylaxix against nutritional anemia)

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
No knowledge	1	7.7	-	-	1	7.1
IFS tablets considered harmful to babies in womb	2	15.4	1	100.0	3	21.4
Can't say	11	84.6	-	-	11	78.6

*Multiple response

....147

Appendix Table 3.9e

Odd beliefs and practices of dais as perceived by trainers according to location(Family planning)

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Afraid of FP/no belief in FP	3	23.1	-	-	3	21.4
IUD considered harmful	1	7.7	-	-	1	7.1
Sterilization weakens a person	3	23.1	-	-	3	21.4
FP makes a man unfit for sexual act	1	7.7	-	-	1	7.1
Averting birth is a sinful act	6	46.2	1	100.0	7	50.0
Others	5	38.5	-	-	5	35.7
Can't say	1	7.7	-	-	1	7.1

*Multiple response

Appendix Table 3.10

Total number of days for class room activities as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
As per guide-lines	7	53.9	-	-	7	50.0
2 days	2	15.4	-	-	2	14.3
7 - 8 days	1	7.7	-	-	1	7.1
11 -12 days	1	7.7	1	100.0	2	14.3
15 -16 days	1	7.7	-	-	1	7.1
Can't say	1	7.7	-	-	1	7.1
Total	13	100.0	1	100.0	14	100.0

....148

Appendix Table 3.11

Number of days for clinic activities as reported by trainers according to location

Days	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
As per guidelines	7	53.9	-	-	7	50.0
2 days	2	15.4	-	-	2	14.3
3 - 4 days	2	15.4	1	100.0	3	21.4
15-16 days	1	7.7	-	-	1	7.1
Can't Say	1	7.7	-	-	1	7.1
Total	13	100.0	1	100.0	14	100.0

Appendix Table 3.12

Number of days for supervised field activities as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
As per guidelines	7	53.9	1	100.0	8	57.1
2 days	2	15.4	-	-	2	14.3
13-14 days	2	15.4	-	-	2	14.3
Can't say	2	15.4	-	-	2	14.3
Total	13	100.0	1	100.0	14	100.0

Appendix Table 3.13

Number of days for unsupervised field activities as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
As per guidelines	7	53.9	-	-	7	50.0
2 days	2	15.4	-	-	2	14.3
Can't say	4	30.8	1	100.0	5	35.7
Total	13	100.0	1	100.0	14	100.0

...149

Appendix Table 3.14

Number of hours per day for class room activities as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
As per guide lines	7	53.9	-	-	7	50.0
1 - 4 hours	-	-	1	100.0	1	7.1
5 - 8 hours	2	15.4	-	-	2	14.3
Can't say	4	30.7	-	-	4	28.6
Total	13	100.0	1	100.0	14	100.0

Appendix Table 3.15

Number of hours per day for clinical activities as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
As per guidelines	7	53.9	-	-	7	50.0
1 - 4 hours	-	-	1	100.0	1	7.1
5 - 8 hours	2	15.4	-	-	2	14.3
13 -16 hours	1	7.7	-	-	1	7.1
Can't say	3	23.1	-	-	3	21.4
Total	13	100.0	1	100.0	14	100.0

....150

Appendix Table 3.16

Number of hours per day for supervised field activities as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
As per guidelines	7	53.9	-	-	7	50.0
9 - 12 hours	-	-	1	100.0	1	7.1
21 + hours	3	23.1	-	-	3	21.4
Can't say	3	23.1	-	-	3	21.4
Total	13	100.0	1	100.0	14	100.0

Appendix Table 3.17

Number of hours per day for unsupervised field activities as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
As per guidelines	7	53.9	-	-	7	50.0
21 + hours	1	7.7	-	-	1	7.1
Can't say	5	38.4	1	100.0	6	42.9
	13	100.0	1	100.0	14	100.0

. ..151

Appendix Table 3.18

Topics on which lesson plans prepared as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Not prepared	1	7.7	-	-	1	7.1
ANC and PNC care	8	61.5	-	-	8	57.1
Conducting delivery/ management of normal delivery	4	30.8	-	-	4	28.6
Asceptic techniques	1	7.7	-	-	1	7.1
Care of new born	2	15.4	-	-	2	14.3
Care of cord	1	7.7	-	-	1	7.1
FP methods and their role	1	7.7	-	-	1	7.1
Nutrition of mother and baby	1	7.7	-	-	1	7.1
Need for immunization	3	23.1	-	-	3	21.4
N.A.	-	-	1	100.0	1	7.1

NOTE: Multiple response

....152

Appendix Table 3.19

Teaching methods used as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Lecture	13	100.0	1	100.0	14	100.0
Lecture cum discussion	13	100.0	1	100.0	14	100.0
Demonstration cum discussion	13	100.0	1	100.0	14	100.0
Return demonstration cum discussion	13	100.0	1	100.0	14	100.0
Group discussion	13	100.0	1	100.0	14	100.0
Role play	5	38.5	-	-	5	35.7
Observational visits	11	84.6	1	100.0	12	85.7
Case demonstration	13	100.0	1	100.0	14	100.0

NOTE: Multiple response

.....153

Appendix Table 320

Teaching methods used in case of various Family Planning methods as reported by trainers

Teaching methods used	Nirodh						Foam Tablets						Jelly					
	ANM PHC		ANM SC		Total		ANM PHC		ANM SC		Total		ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Lecture	10	76.9	-	-	10	71.4	6	46.2	-	-	6	42.9	5	38.5	-	-	5	35.7
Lecture cum discussion	1	7.7	1	100.0	2	14.3	1	7.7	-	--	1	7.1	1	7.7	-	-	1	7.1
Demonstration cum discussion	1	7.7	-	-	1	7.1	1	7.7	-	-	1	7.1	2	15.4	-	-	2	14.3
Group discussion	1	7.7	-	-	1	7.1	2	15.4	1	100.0	3	21.4	2	15.4	1	100.0	3	21.4
Role play	1	7.7	-	-	1	7.1												
Can't say	-	-	-	-	-	-	3	23.1	-	-	3	21.4	3	23.1	-	-	3	21.4

....154 ...Contd.

Appendix Table 3.20 (Contd.)

	Oral Pills						IUD						Sterilization						MTP					
	ANM PHC		ANM SC		Total		ANM PHC		ANM SC		Total		ANM PHC		ANM SC		Total		ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
ure	9	69.2	-	-	9	64.3	7	53.9	-	-	7	50.0	9	69.2	-	-	9	64.3	10	76.9	-	-	10	71.4
re/ssion	2	15.4	1	100.0	3	21.4	3	21.4	1	100.0	4	28.6	2	15.4	-	-	2	14.3	1	7.7	1	100.0	2	14.3
stra-cum ssion	3	23.1	-	-	3	21.4	3	23.1	-	-	3	21.4	2	15.4	-	-	2	14.3	-	-	-	-	-	-
dis-on	-	-	-	-	-	-	2	15.4	-	-	2	14.3	1	7.7	1	100.0	2	14.3	-	-	-	-	-	-
say	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	15.4	-	-	2	14.3

NOTE: Multiple response

....155

Appendix Table 3.21

Demonstrations to improve Dai's practices given by trainers(Aseptic Techniques)

Demonstration given	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Sterilization of instruments before use	6	46.2	1	100.0	7	50.0
Personal hygiene	8	61.5	1	100.0	9	64.3
Use of Dettol	1	7.7	-	-	1	7.1
Proper environmental sanitation	2	15.4	-	-	2	14.3
Others	1	7.7	-	-	1	7.1

Note: Multiple response

Appendix Table 3.22

Demonstrations to improve Dai..s practices given by trainers(General health check up)

Demonstration given	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Regular check up of ANC mothers from 3rd month of pregnancy	4	30.8	1	100.0	5	35.7
Balanced diet	7	53.9	-	-	7	50.0
Additional food to 6 year olds	1	7.7	-	-	1	7.1
PNC/care/ check up	1	7.7	-	-	1	7.1
Check up of general conditions of baby	2	15.4	1	100.0	3	21.4
Check up for complications like PEM etc.	1	7.7	-	-	1	7.1
Urine and blood test	1	7.7	-	-	1	7.1
Others	4	30.8	-	-	4	28.6

Note: Multiple response

....156

Appendix Table 3.23

Demonstrations to improve Dai's practices given by trainers (Immunization)

Demonstration given	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
TT for mother	6	46.2	-	-	6	42.9
Small-pox, BCG, DPT, Polio vaccine for babies	10	77.0	1	100.0	11	78.6
Booster dose of DPT & Polio for children	1	7.7	1	100.0	2	14.3

NOTE: Multiple response

Appendix Table 3.24

Demonstration to improve Dai's practices given by trainers (Management of labour)

Demonstration given	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
How to listen to foetal heart beats	1	7.7	-	-	1	7.1
Conduct of labour	3	23.1	-	-	3	21.4
Sterilization of instrument before use	6	46.2	1	100.0	7	50.0
Placing mother in comfortable position	3	23.1	-	-	3	21.4
Waiting for expulsion of placenta	1	7.7	-	-	1	7.1

....157

Appendix Table 3.25

Demonstration to improve Dai's practices given by trainers (Family Planning)

Demonstration given	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Spacing of children	1	7.7	-	-	1	7.1
IUD	6	46.2	-	-	6	42.9
Oral pills	6	46.2	-	-	6	42.9
Sterilization	4	30.8	1	100.0	5	35.7
Nirodh	9	69.3	1	100.0	10	71.4

NOTE: Multiple response

Appendix Table 3.26

Training facilities available as reported by trainers according to location

Facilities	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Black board with chalk	11	84.6	-	-	11	78.6
Dai kit for demonstration	13	100.0	1	100.0	14	100.0
Dummy with Foetal doll	7	53.9	-	-	7	50.0
Models	7	53.9	-	-	7	50.0
Charts	9	69.2	1	100.0	10	71.4
Stove in working order	12	92.3	1	100.0	13	92.9
Kerosene oil	12	92.3	1	100.0	13	92.9
Utensils for boiling	13	100.0	1	100.0	14	100.0
Test tubes	12	92.3	1	100.0	13	92.9
Equipment for albumin test	12	92.3	1	100.0	13	92.9
Equipment for sugar test	12	92.3	1	100.0	13	92.9
Spirit lamp	12	92.3	1	100.0	13	92.9
BP apparatus with stethoscope	12	92.3	1	100.0	13	92.9
Thermometer	11	84.6	1	100.0	12	85.7
Anema	12	92.3	1	100.0	13	92.9
Weighing machine	12	92.3	1	100.0	13	92.9
Facilities for Hb estimation	12	92.3	1	100.0	13	92.9

NOTE: Multiple response

Appendix Table 3.27

Contents of Evaluation of trainees as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Did not evaluate	1	7.7	-	-	1	7.1
Oral test only	8	61.5	-	-	8	57.1
Questions & Quizes	1	7.7	-	-	1	7.1
ANC & PNC Care	2	15.4	-	-	2	14.3
Conduct of normal delivery	4	30.8	-	-	4	28.6
Aseptic techniques	2	15.4	-	-	2	14.3
Conditions for referral	1	7.7	-	-	1	7.1
Care of new born	-	-	1	100.0	1	7.1
Care of cord	-	-	1	100.0	1	7.1
FP methods	1	7.7	-	-	1	7.1
Demonstration of delivery	1	7.7	-	-	1	7.1

NOTE: Multiple response

...159

Appendix Table 4.1

Major functions and activities of Dai as perceived by trainers

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Registration of ANC cases	2	15.4	-	-	2	14.3
Conduct delivery under hygienic conditions	1	7.7	-	-	1	7.1
To conduct deliveries efficiently	2	15.4	-	-	2	14.3
Adopt aseptic techniques	-	-	1	100.0	1	7.1
Use of sterilized instruments	1	7.7	-	-	1	7.1
Conduct comfortable and easy delivery	1	7.7	1	100.0	2	14.3
Refer complicated cases	2	15.4	-	-	2	14.3
Cooperate in immunization programmes	3	23.1	-	-	3	21.4
Motivate FP cases	4	30.8	-	-	4	28.6
Can't say	6	46.2	-	-	6	42.9

NOTE: Multiple response

Appendix Table 4.2

Cooperation received from trained Dais as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Helps in registration of births and deaths	1	7.7	-	-	1	7.1
Helps in registration of ANC cases	6	46.2	1	100.0	7	50.0
Helps in getting TT for mother	4	30.8	-	-	4	28.6
Refers cases/helps in conducting deliveries	3	23.1	-	-	3	21.4
Refers complicated cases	2	15.4	-	-	2	14.3
Helps in giving PNC care	1	7.7	1	100.0	2	14.3
Helps in immunization camps	4	30.8	-	-	4	28.6
Helps in motivation of FP cases	12	92.4	1	100.0	13	92.9

NOTE: Multiple response

....160

Appendix Table 4.3

Cooperation received from untrained dais as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
No association	1	7.7	-	-	1	7.1
No cooperation	7	53.9	-	-	7	50.0
Helps in registration of births and deaths	1	7.7	-	-	1	7.1
Helps in registration of ANC cases	2	15.4	1	100.0	3	21.4
Refer cases/help in conducting delivery	1	7.7	-	-	1	7.1
Helps in PNC cases	1	7.7	-	-	1	7.1
Helps in immunization camps	1	7.7	-	-	1	7.1

NOTE: Multiple response

Appendix Table 4.4

Shortcomings noticed in midwifery practices of dais as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
No shortcomings	2	15.4	1	100.0	3	21.4
Lack personal hygiene	5	38.5	-	-	5	35.7
Do not boil/sterilize instruments used for cutting the cord	5	38.5	-	-	5	35.7
Use anything available to cut the cord	2	15.4	-	-	2	14.3
Put the mother in uncomfortable position while conducting the delivery	9	69.2	-	-	9	64.3
Do not allow sufficient time for expulsion of placenta	1	7.7	-	-	1	7.1
Do not take care of cord	1	7.7	-	-	1	7.1
Forcibly pull the child during delivery	1	7.7	-	-	1	7.1
Others	1	7.7	-	-	1	7.1

NOTE: Multiple response

....161

Appendix Table 4.5

Improvements noticed in the midwifery practices of trained dais as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
No follow-up	1	7.7	-	-	1	7.1
Observe better personal hygiene	9	69.3	-	-	9	64.3
Follow instructions carefully	1	7.7	-	-	1	7.1
Gives better ANC care	2	15.4	-	-	2	14.3
Send mothers for regular check-up at SC/PHC	1	7.7	-	-	1	7.1
Send mothers for getting TT	1	7.7	-	-	1	7.1
Sterilize instruments, pads and ligates	9	69.3	1	100.0	10	71.4
Use kits/scissors to cut cord	2	15.4	-	-	2	14.3
Use rubber sheets	1	7.7	-	-	1	7.1
Put mothers in comfortable position	6	46.2	-	-	6	42.9
Use clean cloth for padding	1	7.7	-	-	1	7.1
Take proper care of cord	1	7.7	-	-	1	7.1
Give proper bath to baby	2	15.4	1	100.0	3	21.4
Prepare and give anema to mothers	-	-	1	100.0	1	7.1

NOTE: Multiple response

Appendix Table 4.6

Methods employed to ensure that right skills are imparted during training as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Through questions/Quizzes	4	30.8	1	100.0	5	35.7
Asking dais to discuss	3	23.1	1	100.0	4	28.6
By their return demonstration	3	23.1	-	-	3	21.4
Oral test at the end of training	1	7.7	-	-	1	7.1
Observing at the time of deliveries	2	15.4	-	-	2	14.3
Can't say	1	7.7	-	-	1	7.1

NOTE: Multiple response

....162

Appendix Table 4.7

Methods used to help slow learning dais as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
By repeated explanation/clarification/discussion/demonstration	11	84.6	-	-	11	78.6
By explaining the same point in different views	5	38.5	-	-	5	35.7
By supervising deliveries	3	23.1	-	-	3	21.4
By involving them to conduct deliveries	1	7.7	-	-	1	7.1

NOTE: Multiple response

Aprendix Table 4.8

Specific guidance provided during follow-up visits to trained dais as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
No follow-up	1	7.7	-	-	1	7.1
To observe better personal hygiene	1	7.7	-	-	1	7.1
Clarify concepts taught	1	7.7	-	-	1	7.1
Advise to send mothers for registration	6	46.2	1	100.0	7	50.0
Advise to send mothers for TT	3	23.1	1	100.0	4	28.6
Advise to refer complicated cases	1	7.7	-	-	1	7.1
Advise to send mothers to take IFS tablets	1	7.7	-	-	1	7.1
Advise to sterilize instruments	6	46.2	-	-	6	42.1
Advise to put mothers in comfortable position	2	15.4	-	-	2	14.3
Advise to motivate for FP cases	4	30.8	-	-	4	28.6
Advise mothers for immunization	2	15.4	-	-	2	14.3
Advise how to handle new born	3	23.1	-	-	3	21.4
Others	2	15.4	1	100.0	3	21.4

NOTE: Multiple response

....163

Appendix Table 4.9

Support and guidance from supervisors as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Provides immunization schedule	1	7.7	-	-	1	7.1
Gives demonstrations	2	15.4	-	-	2	14.3
Assists in preparatior of classroom lectures	3	23.1	-	-	3	21.4
Participates in classroom sessions	10	76.9	1	100.0	11	78.6
Others	2	15.4	-	-	2	14.3

NOTE: Multiple response

....164

Appendix Table 4.10

Reasons for perceiving training as helpful as reported by trained dais according location

	PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%
Learnt new techniques	9	21.5	4	19.1	13	20.7
Learnt scientific midwifery practices	13	30.9	4	19.1	17	27.0
Better skilled to attend to complicated cases	7	16.7	4	19.1	11	17.5
Learnt the significance of immunization	4	9.6	-	-	4	6.4
Get more cases now	1	2.4	-	-	1	1.6
Can advise on cleanliness	7	16.7	2	9.6	9	14.3
Use sterilized instruments to avoid tetanus	4	9.5	4	19.1	8	12.7
Can take better care of cord	1	2.4	1	4.8	2	3.2
More confident in preparation of home confinement	-	-	2	9.6	2	3.2
Can advise for FP better	4	9.5	-	-	4	6.4
Get more money	1	2.4	1	4.8	2	3.2
Put mothers in comfortable position now	2	4.8	1	4.8	3	4.8
Get respect from community	3	7.2	3	14.3	6	9.6
Others	-	-	2	9.5	2	3.2

NOTE: Multiple response

....165

Appendix Table 4.11

Number of cases delivered as reported by dais according to location and training status

	Trained dai						Untrained dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
None	1	2.4	1	4.8	2	3.2	-	-	-	-	-	-	1	1.3	1	2.0	2	1.5
1-3	10	23.3	2	9.5	12	19.1	20	52.6	12	41.4	32	47.8	30	37.5	14	28.0	44	33.8
4-6	18	42.9	10	47.6	28	44.4	13	34.2	15	57.7	28	41.8	31	38.3	25	50.0	56	43.1
7-10	10	23.8	4	19.1	14	22.2	3	7.9	2	6.9	5	7.5	13	16.2	6	12.0	19	14.6
11-13	3	7.1	2	9.5	5	7.9	2	5.3	-	-	2	3.0	5	6.2	2	4.0	7	5.4
14 +	-	-	1	4.8	1	1.6	-	-	-	-	-	-	-	-	1	2.0	1	0.8
Can't say	-	-	1	4.8	1	1.6	-	-	-	-	-	-	-	-	1	2.0	1	0.8
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 166

Appendix Table 4.12

Number of deliveries conducted independently as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
None	1	2.4	1	4.8	2	3.2	1	2.6	-	-	1	1.5	2	2.5	1	2.0	3	2.3
One	2	4.3	-	-	2	3.2	1	2.6	2	6.9	3	4.5	3	3.7	2	4.0	5	3.8
Two	7	16.7	2	9.5	9	14.3	3	21.1	2	6.9	10	14.9	15	13.7	4	3.0	19	14.6
Three	2	4.3	-	-	2	3.2	11	29.0	3	27.6	19	28.4	13	16.2	3	16.0	21	16.1
Four	8	19.1	2	9.5	10	15.9	4	10.5	4	13.8	3	11.9	12	15.0	6	12.0	18	13.8
Five	4	9.5	7	33.3	11	17.5	3	7.9	4	13.8	7	10.5	7	8.7	11	22.0	18	13.8
Six	17	40.5	3	33.1	25	39.7	10	26.3	8	27.6	18	26.9	27	33.7	16	32.0	43	33.1
Seven+	1	2.4	-	-	1	1.6	-	-	1	3.5	1	1.5	1	1.2	1	2.0	2	1.5
Can't say	-	-	1	4.3	1	1.6	-	-	-	-	-	-	-	-	1	2.0	1	0.8
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 167

Appendix Table 4.13

Number of cases delivered with the help of HW(F)/ANM, as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
None	39	92.9	20	95.2	59	93.7	37	97.4	29	100.0	66	93.5	76	95.0	49	98.0	125	96.1
One	1	2.4	-	-	1	1.6	-	-	-	-	-	-	1	1.2	-	-	1	0.3
Two	1	2.4	-	-	1	1.6	1	2.6	-	-	1	1.5	2	2.5	-	-	2	1.5
Three+	1	2.4	-	-	1	1.6	-	-	-	-	-	-	1	1.3	-	-	1	0.3
Can't say	-	-	1	4.3	1	1.6	-	-	-	-	-	-	-	-	1	2.0	1	0.8
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 168

Appendix Table 4.14

Number of pregnant mothers contacted during the past three months as reported by dais According to location and training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
None	8	19.0	5	23.8	13	20.6	18	47.4	17	53.6	35	52.2	26	32.5	22	44.0	48	36.9
1-5	18	42.9	8	33.1	26	41.3	10	26.3	9	31.0	19	23.4	28	35.0	17	34.0	45	34.6
5-10	14	33.3	6	23.6	20	31.8	6	15.8	2	6.9	8	11.9	20	25.0	8	16.0	28	21.5
10-15	2	4.8	-	-	2	3.2	2	5.3	-	-	2	3.0	4	5.0	-	-	4	3.1
15-20	-	-	1	4.8	1	1.6	1	2.6	-	-	1	1.5	1	1.2	1	2.0	2	1.5
20-25	-	-	-	-	-	-	1	2.6	-	-	1	1.5	1	1.2	-	-	1	0.8
25+	-	-	-	-	-	-	-	-	1	3.5	1	1.5	-	-	1	2.0	1	0.8
Can't say	-	-	1	4.8	1	1.6	-	-	-	-	-	-	-	-	1	2.0	1	0.8
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

....169

Appendix Table 4.15

Number of mothers registered at subcentres as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
None	14	33.3	7	33.3	21	33.3	10	26.3	15	51.7	25	37.3	24	30.0	22	44.0	46	35.4
One	3	7.1	2	9.5	5	7.9	1	2.6	2	6.9	3	4.5	4	5.0	4	3.0	8	6.1
Two	6	14.3	3	14.3	9	14.3	9	23.7	4	13.8	13	19.4	15	18.7	7	14.0	22	16.9
Three	5	11.9	2	9.5	7	11.1	10	26.3	4	13.8	14	20.9	15	18.7	6	12.0	21	16.1
Four	3	7.1	2	9.5	5	7.9	1	2.6	-	-	1	1.5	4	5.0	2	4.0	6	4.6
Five	5	11.9	-	-	5	7.9	2	5.3	1	3.5	3	4.5	7	3.7	1	2.0	8	6.1
Six+	3	7.1	4	19.1	7	11.1	2	5.3	1	3.5	3	4.5	5	6.2	5	10.0	10	7.7
Can't say	3	7.1	1	4.3	4	6.3	3	7.9	2	6.9	5	7.5	6	7.5	3	6.0	9	6.9
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 170

Appendix Table 4.16

Number of mothers receiving atleast two doses of Tetanus Toxoid as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
None	10	23.8	5	23.8	15	23.8	9	23.7	15	51.7	24	35.8	19	23.7	20	40.0	39	30.0
One	4	9.5	3	14.3	7	11.1	2	5.3	2	6.9	4	6.0	6	7.5	5	10.0	11	8.5
Two	9	21.4	3	14.3	12	19.1	9	23.7	5	17.2	14	20.9	18	22.5	8	16.0	26	20.0
Three	4	9.5	2	9.5	6	9.5	10	26.3	3	10.3	13	19.4	14	17.5	5	10.0	19	14.6
Four	3	7.1	3	14.3	6	9.5	1	2.6	-	-	1	1.5	4	5.0	3	6.0	7	5.4
Five	3	7.1	-	-	3	4.8	1	2.6	1	3.5	2	3.0	4	5.0	1	2.0	5	3.8
Six or more	6	14.3	3	14.3	9	14.3	3	7.9	1	3.5	4	5.0	9	11.2	4	8.0	13	10.0
Can't say	3	7.1	2	9.5	5	7.9	3	7.9	2	6.9	5	7.5	6	7.5	4	8.0	10	7.7
Total :	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	60	100.0

.... 171

Appendix Table 4.17

Number of mothers receiving prophylaxis against nutritional anemia as reported by dais according to location and training status

	Trained Dai						Untrained dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
None	10	23.3	3	33.1	18	23.6	7	13.9	15	51.7	22	33.3	17	21.2	23	46.0	40	30.3
One	4	9.5	1	4.3	5	7.9	4	10.3	3	10.3	7	10.6	8	10.0	4	3.0	12	9.2
Two	9	21.4	3	14.3	12	19.1	7	13.9	4	13.3	11	16.7	16	20.0	7	14.0	23	17.7
Three	5	11.9	2	9.5	7	11.1	11	20.7	3	10.3	14	21.2	16	20.0	5	10.0	21	16.1
Four	2	4.8	2	9.5	4	6.4	1	2.7	-	-	1	1.5	3	3.7	2	4.0	5	3.8
Five	4	9.5	-	-	4	6.4	1	2.7	1	3.5	2	3.0	5	6.2	1	2.0	6	4.6
Six+	5	11.9	3	14.3	3	12.7	3	3.1	1	3.5	4	6.1	8	10.0	4	3.0	12	9.2
Can't say	3	7.1	2	9.5	5	7.9	4	10.3	2	6.9	6	9.0	7	8.7	4	3.0	11	8.5
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 172

Appendix Table 4.18

Number of babies died as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
None	30	71.4	16	76.2	46	73.0	29	76.3	22	75.9	51	76.1	59	73.7	38	76.0	97	74.6
One	9	21,4	3	14.3	12	19.1	4	10.5	2	6.9	6	9.0	13	16.2	5	10.0	18	13.8
Two	3	7.1	1	4.8	4	6.4	-	-	1	3.5	1	1.5	3	3.8	2	4.0	5	3.8
Three	-	-	-	-	-	-	2	5.3	-	-	2	3.0	2	2.5	-	-	2	1.5
Still birth	-	-	1	4.8	1	1.6	3	7.9	4	13.8	7	10.5	3	3.8	5	10.0	8	6.1
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 173

Appendix Table 4.19

Cause of death of first case as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Still birth	1	2.4	2	9.5	3	4.8	5	13.2	5	17.2	10	14.9	6	7.5	7	14.0	13	10.0
Breach delivery	2	4.8	-	-	2	3.2	-	-	-	-	-	-	2	2.5	-	-	2	1.5
Fever	1	2.4	-	-	1	1.6	-	-	-	-	-	-	1	1.2	-	-	1	0.8
Tetanus	1	2.4	-	-	1	1.6	-	-	-	-	-	-	1	1.2	-	-	1	0.8
Dehydration	-	-	-	-	-	-	1	2.6	-	-	1	1.5	1	1.2	-	-	1	0.8
Thrush	-	-	1	4.8	1	1.6	-	-	-	-	-	-	-	-	1	2.0	1	0.8
Genital problem	1	2.4	1	4.8	2	3.2	-	-	-	-	-	-	1	1.2	1	2.0	2	1.5
Premature birth	1	2.4	1	4.8	2	3.2	2	5.3	2	6.9	4	6.0	3	3.7	3	6.0	6	4.6
Respiratory	1	2.4	-	-	1	1.6	1	2.6	-	-	1	1.5	2	2.5	-	-	2	1.5
Digestive	2	4.8	1	4.8	3	4.8	-	-	-	-	-	-	2	2.5	1	2.0	3	2.3
No death	29	69.1	15	71.4	44	69.8	28	73.7	22	75.9	50	74.6	57	71.2	37	74.0	94	72.3
Can't say	3	7.1	-	-	3	4.8	1	2.6	-	-	1	1.5	4	5.0	-	-	4	3.1
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 174

Appendix Table 4.20

Age at death of first case as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Still birth	1	2.4	2	9.5	3	4.8	5	13.2	5	17.2	10	14.9	6	7.5	7	14.0	13	10.0
Within 24 hours	2	4.8	-	-	2	3.2	-	-	-	-	-	-	2	2.5	-	-	2	1.5
1-7 days	5	11.9	1	4.8	6	9.5	1	2.6	1	3.5	2	3.0	6	7.5	2	4.0	8	6.1
8-28 days	2	4.8	2	9.5	4	6.4	3	7.9	-	-	3	4.5	5	6.2	2	4.0	7	5.4
29-90 days	1	2.4	1	4.8	2	3.2	-	-	-	-	-	-	1	1.2	1	2.0	2	1.5
No death	29	69.1	15	71.4	44	69.8	28	73.7	22	75.9	50	74.6	57	71.2	37	74.0	94	72.3
Don't say	2	4.8	-	-	2	3.2	1	2.6	1	3.5	2	3.0	3	3.7	1	2.0	4	3.1
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 175

Appendix Table 4.21

Cause of death of second case as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Still birth	3	7.1	2	9.5	5	7.9	3	7.9	2	6.9	5	7.5	6	7.5	4	8.0	10	7.7
Flrush	-	-	-	-	-	-	1	2.6	-	-	1	1.5	1	1.2	-	-	1	0.8
Premature birth	1	2.4	-	-	1	1.6	-	-	1	3.5	1	1.5	1	1.2	1	2.0	2	1.5
No death	36	85.7	19	90.5	55	87.3	34	89.5	26	89.7	60	89.6	70	87.5	45	90.0	115	88.5
Can't say	2	4.8	-	-	2	3.2	-	-	-	-	-	-	2	2.5	-	-	2	1.5
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 176

Appendix Table 4.22

Age at death of second case as reported by dais according to location & training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
till birth	3	7.1	2	9.5	5	7.9	3	7.9	2	6.9	5	7.5	6	7.5	4	8.0	10	7.7
within 24 hours	-	-	-	-	-	-	-	-	1	3.5	1	1.5	-	-	1	2.0	1	0.8
1 - 7days	1	2.4	-	-	1	1.6	1	2.6	-	-	1	1.5	2	2.5	-	-	2	1.5
No death	36	85.7	19	90.5	55	87.3	34	89.5	26	89.7	60	89.6	70	87.5	45	90.0	115	88.5
Can't say	2	4.8	-	-	2	3.2	-	-	-	-	-	-	2	2.5	-	-	2	1.5
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 177

Appendix Table 4.23

Advice regarding Family Planning as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Advise FP	35	83.3	17	81.0	52	82.5	13	34.2	6	20.7	19	28.4	48	60.0	23	46.0	71	54.6
Do not advise FP	7	16.7	3	14.3	10	15.9	25	65.8	23	79.3	48	71.6	32	40.0	26	52.0	58	44.6
Can't say	-	-	1	4.8	1	1.6	-	-	-	-	-	-	-	-	1	2.0	1	0.8
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 178

Appendix Table 4.24

Reasons for advising family planning as reported by dais according to location and training ststus

	Trained dai						Untrained dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Did not advise FP	8	19.1	3	14.3	11	17.5	25	65.8	23	79.3	48	71.6	33	41.2	26	52.0	59	45.4
To avoid unwanted pregnancy	6	14.3	1	4.8	7	11.1	1	2.6	-	-	1	1.5	7	8.7	1	2.0	8	6.2
In case no child is needed	5	11.9	2	9.5	7	11.1	-	-	1	3.5	1	1.5	5	6.3	3	6.0	8	6.2
Can't say	23	54.8	15	71.4	38	60.3	12	31.6	5	17.2	17	25.4	35	43.8	20	40.0	55	42.2
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.... 179

Appendix Table 4.25

Reasons for not advising family planning as reported by dais according to location and training status

	Trained dai						Untrained dai						Total					
	PHC/SC		Remote		Total		PHC/SC		remote		Total		PHC/SC		Remote		total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Advise FP	34	81.0	17	81.0	51	81.0	13	34.2	6	20.7	19	28.4	47	58.7	23	46.0	70	53.8
No knowledge of FP	4	9.5	-	-	4	6.4	8	21.0	11	37.9	19	28.4	12	15.0	11	22.0	23	17.7
None prepared to FP	1	2.4	1	4.8	2	3.2	2	5.3	1	3.5	3	4.5	3	3.7	2	4.0	5	3.8
Not my job to advise Fp	-	-	1	4.8	1	1.6	9	23.7	4	13.8	13	19.4	9	11.2	5	10.0	14	10.8
I will lose my job	-	-	-	-	-	-	1	2.6	-	-	1	1.5	1	1.2	-	-	1	0.8
Not taught in trg.	2	4.8	-	-	2	3.2	-	-	-	-	-	-	2	2.5	-	-	2	1.5
No belief	-	-	-	-	-	-	1	2.6	-	-	1	1.5	1	1.2	-	-	1	0.8
More children more income	-	-	1	4.8	1	1.6	-	-	-	-	-	-	-	-	1	2.0	1	0.8
Children are God's gift	-	-	-	-	-	-	-	-	1	3.5	1	1.5	-	-	1	2.0	1	0.8
Can't say	1	4.8	-	-	1	1.6	5	13.2	5	17.2	10	14.9	6	7.5	5	10.0	11	8.5

Note: Multiple response

.... 180

Appendix Table 4.26

No. of persons motivated for various family planning methods as reported by dais according to location & training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
Niroth	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Ncne	35	83.3	18	85.7	53	84.1	38	100.0	29	100.0	67	100.0	73	91.3	47	94.0	120	92.3
1 - 5 cases	7	16.7	3	14.3	10	15.9	-	-	-	-	-	-	7	8.7	3	6.0	10	7.7
Oral pills																		
Icne	41	97.6	20	95.2	61	96.8	38	100.0	29	100.0	67	100.0	79	98.7	49	98.0	128	98.5
- 5 cases	1	2.4	1	4.8	2	3.2	-	-	-	-	-	-	1	1.3	1	2.0	2	1.5
U D																		
cne	41	97.6	20	95.2	61	96.8	37	97.4	29	100.0	66	98.5	78	97.5	49	98.0	127	97.7
- 5 cases	1	2.4	1	4.8	2	3.2	1	2.6	-	-	1	1.5	2	2.5	1	2.0	3	2.3
terilization																		
cne	12	28.6	8	38.1	20	31.8	18	47.4	19	65.5	37	55.2	30	37.5	27	54.0	57	43.8
5 cases	28	66.6	11	52.4	39	61.9	17	44.7	9	31.0	26	36.8	35	56.2	20	40.0	65	50.0
60 cases	2	4.8	2	9.5	4	6.4	3	7.9	-	-	3	4.5	5	6.3	2	4.0	7	5.4
+	-	-	-	-	-	-	-	-	1	3.5	1	1.5	-	-	1	2.0	1	0.8
P																		
ne	42	100.0	18	85.7	60	95.2	38	100.0	29	100.0	67	100.0	80	100.0	47	94.0	127	97.7
5 cases	-	-	3	14.3	3	4.8	-	-	-	-	-	-	-	-	3	6.0	3	2.3

Appendix Table 4.27

Pattern of advice given to mothers as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Whether advised for registration	23	54.8	7	33.3	30	47.6	6	15.8	4	13.8	10	14.9	29	36.2	11	22.0	40	30.8
Regular check up	28	66.7	13	61.9	41	65.1	10	26.3	6	20.7	16	23.9	38	47.5	19	38.0	57	43.8
Immunization (TT)	31	73.8	14	66.7	45	71.4	8	21.1	4	13.8	12	17.9	39	48.7	18	36.0	57	43.8
Nutrition for mother	14	33.3	4	19.1	18	28.6	6	15.8	1	3.5	7	10.5	20	25.0	5	10.0	25	19.2
Preparation for confinement	12	28.6	4	19.1	16	25.4	5	13.2	5	17.2	10	14.9	17	21.2	9	18.0	26	20.0
Prophylaxis against nutritional anaemia	21	50.0	10	47.6	31	49.2	6	15.8	4	13.8	10	14.9	27	33.7	14	28.0	41	31.5
FP	14	33.3	8	38.1	22	34.9	2	5.3	2	6.9	4	8.0	16	20.0	10	20.0	26	20.0
Personal Hygiene	11	26.2	4	19.1	15	23.8	3	7.9	2	6.9	5	7.5	14	17.5	6	12.0	20	15.4
Others	-	-	-	-	-	-	1	2.6	-	-	1	1.5	1	1.2	-	-	1	0.8
No contact	8	19.1	5	23.8	13	20.6	18	47.4	17	58.6	35	52.2	26	32.5	22	44.0	48	36.9

NOTE: Positive responses only

.... 182

Appendix Table 4.28

Pattern of advice given by dais as reported by mothers according to location and training status of dais attending on them

Advice given during latest pregnancy	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Advice for TT	106	45.1	50	46.3	156	45.5	31	16.0	11	6.8	42	11.8	137	31.9	61	22.7	198	28.4
Advice for prophylaxis against nutritional anemia	103	43.8	51	47.2	154	44.9	29	14.9	10	6.2	39	11.0	132	30.8	61	22.7	193	27.6
Preparation of home confinement	131	55.7	53	49.1	184	53.6	65	33.5	31	19.2	96	27.0	196	45.7	84	31.2	280	40.1
Regular check up	82	34.9	42	38.9	124	36.1	26	13.4	11	6.8	37	10.4	108	25.2	53	19.7	161	23.1

...Contd ...183

Appendix Table 4.28 (Contd.)

During previous pregnancy	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Advice for TT prophylaxis against nutritional anemia	15	26.8	10	34.5	25	29.4	3	4.9	3	7.0	6	5.8	18	15.4	13	18.1	31	16.4
	12	21.4	10	34.5	22	25.9	2	3.3	2	4.6	4	3.9	14	12.0	12	16.6	26	13.8
Preparation of home confinement	21	37.5	10	34.5	31	36.5	10	16.4	7	16.3	17	16.3	31	26.5	17	23.6	48	25.4
Regular check up	6	10.7	6	20.7	12	14.1	3	4.9	2	4.6	5	4.8	9	7.7	8	11.1	17	9.0

NOTE: Positive responses only

.... 184

Appendix Table 4.29

Number of visits made by dai during pregnancy as reported by mothers according to location and training status of dais attending on them

During latest pregnancy	Trained dai						Untrained dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
None	210	89.4	102	94.4	312	91.0	185	95.4	151	93.8	336	94.6	395	92.1	253	94.1	648	92.8
Once	22	9.4	5	4.6	27	7.9	8	4.1	9	5.6	17	4.8	30	7.0	14	5.2	44	6.3
Twice	2	0.8	1	0.9	3	0.9	1	0.5	1	0.6	2	0.6	3	0.7	2	0.7	5	0.7
Six times	1	0.4	-	-	1	0.3	-	-	-	-	-	-	1	0.2	-	-	1	0.1
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0
During previous pregnancy																		
None	44	78.6	26	89.7	70	82.3	52	85.2	38	88.4	90	86.5	96	82.1	64	88.9	160	84.7
Once	5	8.9	-	-	5	5.9	1	1.6	1	2.3	2	1.9	6	5.1	1	1.4	7	3.7
Twice	-	-	-	-	-	-	1	1.6	-	-	1	1.0	1	0.8	-	-	1	0.5
Can't say	7	12.5	3	10.3	10	11.8	7	11.5	4	9.3	11	10.6	14	12.0	7	9.7	21	11.1
Total	56	100.0	29	100.0	85	100.0	61	100.0	43	100.0	104	100.0	117	100.0	72	100.0	189	100.0

.... 185

Appendix Table 4.30

Problems during pregnancy as reported by mothers according to location and training status of dais attending on them

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
lems during st pregnancy	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
	213	90.6	100	92.6	313	91.2	183	94.3	148	91.9	331	93.2	396	92.3	248	92.2	644	92.3
ema of feet	12	5.1	4	3.7	16	4.7	8	4.1	6	3.7	14	3.9	20	4.7	10	3.7	30	4.3
eding	-	-	-	-	-	-	-	-	1	0.6	1	0.3	-	-	1	0.4	1	0.1
ated attack pain	4	1.7	2	1.8	6	1.7	3	1.6	3	1.9	6	1.7	7	1.6	5	1.9	12	1.7
ima with re-																		
ted attack of n	1	0.4	2	1.8	3	0.9	-	-	2	1.2	2	0.6	1	0.2	4	1.5	5	0.7
't say	5	2.1	-	-	5	1.5	-	-	1	0.6	1	0.3	5	1.2	1	0.4	6	0.9
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0
blems during vious pregnancy																		
e	45	80.4	26	89.7	71	83.5	51	83.6	36	83.7	87	83.6	96	82.0	62	86.1	158	83.6
ema of feet	1	1.7	-	-	1	1.2	-	-	-	-	-	-	1	0.9	-	-	1	0.5
eding	-	-	-	-	-	-	-	-	1	2.3	1	1.0	-	-	1	1.4	1	0.5
't say	10	17.9	3	10.3	13	15.3	10	16.4	6	14.0	16	15.4	20	17.1	9	12.5	29	15.3
Total	56	100.0	29	100.0	85	100.0	61	100.0	43	100.0	104	100.0	117	100.0	72	100.0	189	100.0

.... 186

Appendix Table 4.31

Action taken by dai for swelling of feet as reported by mothers according to location and training status of dais attending on them

ction taken uring latest regnancy	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
id not have ny problem	213	90.6	100	92.6	313	91.2	183	94.3	148	91.9	331	93.2	396	92.3	248	92.2	644	92.3
ook patient o subcentre	-	-	1	0.9	1	0.3	1	0.5	-	-	1	0.3	1	0.2	1	0.4	2	0.3
eferred to HC/SC	-	-	-	-	-	-	1	0.5	-	-	1	0.3	1	0.2	-	-	1	0.1
dvised to con- ult private octor	2	0.8	-	-	2	0.6	1	0.5	-	-	1	0.3	3	0.7	-	-	3	0.4
irst contact as not dai	4	1.7	1	0.9	5	1.5	2	1.0	5	3.1	7	2.0	6	1.4	6	2.2	12	1.7
an't say	6	2.5	2	1.8	8	2.3	3	1.5	1	0.6	4	1.1	9	2.1	3	1.1	12	1.7
ot applicable	10	4.3	4	3.7	14	4.1	3	1.5	7	4.3	10	2.8	13	3.0	11	4.1	24	3.4
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0

...Contd.187

Appendix Table 4.31 (Contd:)

tion taken ring pre- ious preg- ancy	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No:	%	No:	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
o problem	45	80.4	26	89.7	71	83.5	51	83.6	36	83.7	87	83.6	96	82.0	62	86.1	158	83.6
ar't say	1	1.7	-	-	1	1.2	-	-	-	-	-	-	1	0.9	-	-	1	0.5
ot applica- le	10	17.9	3	10.3	13	15.3	10	16.4	7	16.3	17	16.3	20	17.1	10	13.9	30	15.9
Total	56	100.0	29	100.0	85	100.0	61	100.0	43	100.0	104	100.0	117	100.0	72	100.0	189	100.0

.....188

Appendix Table 4.32

Number of hours of dai's presence before delivery as reported by mothers according to location and training status of dais attending on them

During latest delivery	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		REmote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Morethan hour	128	54.5	67	62.0	195	56.8	112	57.7	90	55.9	202	56.9	240	55.9	157	58.4	397	56.9
Half hr.	68	28.9	22	20.4	90	26.2	62	32.0	39	24.2	101	28.4	130	30.3	61	22.7	191	27.4
Just before birth	13	5.5	2	1.8	15	4.4	5	2.6	11	6.8	16	4.5	18	4.2	13	4.8	31	4.4
After birth	24	10.2	17	15.7	41	11.9	15	7.7	21	13.0	36	10.1	39	9.1	38	14.1	77	11.0
Can't say	2	0.9	-	-	2	0.6	-	-	-	-	-	-	2	0.5	-	-	2	0.3
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0
During previous delivery																		
More than hour	29	51.8	15	51.7	44	51.8	26	42.6	22	51.2	48	46.1	55	47.0	37	51.4	92	48.7
Half hr	12	21.4	2	6.9	14	16.5	10	16.4	10	23.3	20	19.2	22	18.8	12	16.6	34	18.0
Just before birth	2	3.6	-	-	2	2.3	1	1.6	-	-	1	1.0	3	2.6	-	-	3	1.6
After birth	-	-	3	10.3	3	3.5	8	13.1	4	9.3	12	11.5	8	6.8	7	9.7	15	7.9
Can't say	13	23.2	9	31.0	22	25.9	16	26.2	7	16.3	23	22.1	29	24.8	16	22.2	45	23.8
Total	56	100.0	29	100.0	85	100.0	61	100.0	43	100.0	104	100.0	117	100.0	72	100.0	189	100.0

Appendix Table 4.33

Accompaniment of health worker with dai at the time of delivery as reported by mothers according to location and training status of dais attending on them

During latest delivery	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
None	227	96.6	102	94.4	329	95.9	193	99.5	160	99.4	353	99.4	420	97.9	262	97.4	682	97.7
HW accompanied	6	2.6	5	4.6	11	3.2	-	-	1	0.6	1	0.3	6	1.4	6	2.2	12	1.7
Can't say	2	0.8	1	1.0	3	0.9	1	0.5	-	-	1	0.3	3	0.7	1	0.4	4	0.6
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0
During previous pregnancy																		
HW accompanied	-	-	1	3.4	1	1.2	-	-	-	-	-	-	-	-	1	1.4	1	0.5
None accom.	45	80.4	24	82.8	69	81.2	52	85.2	37	86.0	89	85.6	97	82.9	61	84.7	158	83.6
Can't say	11	19.6	4	13.8	15	17.6	9	14.8	6	14.0	15	14.4	20	17.1	10	13.9	30	15.9
Total	56	100.0	29	100.0	85	100.0	61	100.0	43	100.0	104	100.0	117	100.0	72	100.0	189	100.0

.....190

Appendix Table 4.34

Natal practices of dai during latest delivery as reported by mothers according to location and training status of dais attending on them

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Brought maternity kit	79	33.6	36	33.3	115	33.5	-	-	-	-	-	-	79	18.4	36	13.4	115	16.5
Dai washed her hand	206	87.6	85	78.7	291	76.1	140	72.2	121	75.2	261	73.5	346	80.6	206	76.6	552	79.1
Dai boiled the equipment	123	52.3	70	64.8	193	56.3	49	25.3	34	21.1	83	23.4	172	40.1	104	38.7	276	39.5
Dai gave drink	168	71.5	82	75.9	250	72.9	125	64.4	116	72.0	241	67.9	293	68.3	198	73.6	491	70.3
Comfort the mother	232	98.7	104	96.3	336	98.0	188	96.9	152	94.4	340	95.8	420	97.9	256	95.2	676	96.8
Press mothers abdomen hard	95	40.4	43	39.8	138	40.2	65	33.5	52	32.3	117	33.0	160	37.3	95	35.3	255	36.5
Administered drug	7	3.0	6	5.6	13	3.8	6	3.1	-	-	6	1.7	13	3.0	6	2.2	19	2.7

NOTE: Positive response only

.....191

Appendix Table 4.35

Natal practices of dai during previous pregnancy as reported by mothers according to location and training status of dais attending on them

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
ught mater-ty kit	1	1.8	1	3.4	2	2.3	-	-	-	-	-	-	1	0.9	1	1.4	2	1.1
shed hands	35	62.5	17	58.6	52	61.2	25	41.0	21	48.3	46	44.2	60	51.3	38	52.8	98	51.8
iled equip-nts	11	19.6	10	34.5	21	24.7	5	8.2	8	18.6	13	12.5	16	13.7	18	25.0	34	18.0
ve drink	31	55.4	15	51.7	46	54.1	26	42.6	20	46.5	46	44.2	57	48.7	35	48.6	92	48.7
nfort the ther	44	78.6	20	69.0	64	75.3	42	68.8	29	67.4	71	68.3	86	73.5	49	68.1	135	71.4
ess mothers oman hard	13	23.2	6	20.7	19	22.3	11	18.0	10	23.2	21	20.2	24	20.5	16	22.2	40	21.2
inistered ug	1	1.8	2	6.9	3	3.5	1	1.6	-	-	1	1.0	2	1.7	2	2.8	4	2.1

NOTE: Positive response only.

.....192

Appendix Table 4.36

Instrument used by dai for cutting the cord as reported by mothers according to location and training status of dais attending on them

uring latest delivery	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
cissors	113	48.1	46	42.6	159	46.4	11	5.7	9	5.6	20	5.6	124	28.9	55	20.4	179	25.6
lade	105	44.7	50	46.3	155	45.2	154	79.4	126	78.3	280	78.9	259	60.4	176	72.9	435	62.3
ickle	12	5.1	8	7.4	20	5.8	17	8.8	20	12.4	37	10.4	29	6.8	28	10.4	57	8.2
aife	2	0.8	3	2.8	5	1.5	7	3.6	3	1.9	10	2.8	9	2.1	6	2.2	15	2.1
thers	2	0.8	-	-	2	0.6	1	0.5	-	-	1	0.3	3	0.7	-	-	3	0.4
n't say	1	0.4	1	1.0	2	0.6	4	2.1	3	1.9	7	2.0	5	1.2	4	1.5	9	1.3
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0
ring earlier livery																		
issors	5	8.9	3	10.3	8	9.4	1	1.6	-	-	1	1.0	6	5.1	3	4.2	9	4.8
ade	30	53.6	16	55.2	46	54.1	38	62.3	29	67.4	67	64.4	68	58.1	45	62.5	113	59.8
ckle	4	7.1	4	13.8	8	9.4	5	8.2	5	11.6	10	9.6	9	7.7	9	12.5	18	9.5
ife	1	1.8	1	3.4	2	2.3	1	1.6	-	-	1	1.0	2	1.7	1	1.4	3	1.6
ers	-	-	1	3.4	1	1.2	2	3.3	1	2.3	3	2.9	2	1.7	2	2.8	4	2.1
n't say	16	28.6	4	13.8	20	23.5	14	22.9	8	18.6	22	21.1	30	25.6	12	16.7	42	22.2
otal	56	100.0	29	100.0	85	100.0	61	100.0	43	100.0	104	100.0	117	100.0	72	100.0	189	100.0

Appendix Table 4.37

Natal practices of dais

Latest delivery	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Instrument for cutting the cord boiled	123	52.3	71	65.7	194	56.6	49	25.3	33	20.5	82	23.1	172	40.1	104	38.7	276	39.5
old clothes kept ready	215	91.5	93	86.1	308	89.8	173	89.2	139	86.3	312	87.9	388	90.4	232	86.2	620	88.8
Rubber sheet used	52	22.1	26	24.1	78	22.7	2	1.0	3	1.9	5	1.4	54	12.6	29	10.8	83	11.9

NOTE: Positive responses only

Earlier delivery

Instrument for cutting the cord boiled	11	19.6	10	34.5	21	24.7	5	8.2	8	18.6	13	12.5	16	13.7	18	25.0	34	18.0
old clothes keep ready	37	66.1	19	65.5	56	65.9	41	67.2	26	60.5	67	64.4	78	66.6	45	62.5	123	65.1
Rubber sheet used	2	3.6	1	3.4	3	3.5	-	-	1	2.3	1	1.0	2	1.7	2	2.8	4	2.1

NOTE: Positive responses only.

.....194

Appendix Table 4.38

Number of hours spent by dai during delivery as reported by mothers according to location and training status of dais attending on them

Latest delivery	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
ss than 1 hr.	4	1.7	-	-	4	1.2	1	0.5	1	0.6	2	0.6	5	1.2	1	0.4	6	0.9
1 - 2 hrs.	172	73.2	68	63.0	240	70.0	131	67,5	123	76.4	254	71.5	303	70.6	191	71.0	494	70.8
2 - 3 hrs.	42	17.9	25	23.1	67	19.5	44	22.7	24	14.9	68	19.1	86	20.0	49	18.2	135	19.3
3 - 4 hrs.	12	5.1	9	8.3	21	6.1	10	5.1	7	4.3	17	4.8	22	5.1	16	5.9	38	.5.4
4 - 5 hrs.	2	0.8	1	1.0	3	0.9	1	0.5	1	0.6	2	0.6	3	0.7	2	0.7	5	0.7
5 - 6 hrs.	-	-	1	1:0	1	0.3	3	1.5	-	-	3	0.8	3	0.7	1	0.4	4	0.6
6 hrs. +	2	0.8	4	3.7	6	1.7	2	1.0	2	1.2	4	1.1	4	0.9	6	2.2	10	1.4
Can't say	1	0.4	-	-	1	0.3	2	1.0	3	1.9	5	1.4	3	0.7	3	1.1	6	0.9
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0
vious delivery																		
s than 1 hr.	1	1.8	-	-	1	1.2	-	-	4	9.3	4	3.8	1	0.8	4	5.6	5	2.6
1 - 2 hrs.	18	32.1	15	51.7	33	38.8	29	47.5	20	46.5	49	47.1	47	40.2	35	48.6	82	43.4
2 - 3 hrs.	20	35.7	5	17.2	25	29.4	18	29.5	8	18.6	26	25.0	38	32.5	13	18.0	41	21.7
3 - 4 hrs.	1	1.8	2	6.9	3	3.5	3	4.9	1	2.3	4	3.8	4	3.4	3	4.2	7	3.7
4 - 5 hrs.	1	1.8	1	3.4	2	2.3	-	-	-	-	-	-	1	0.8	1	1.4	2	1.1
5 hrs. +	-	-	1	3.4	1	1.2	-	-	2	4.6	2	1.9	-	-	3	4.2	3	1.6
Can't say	15	26.8	5	17.2	20	23.5	11	18.0	8	18.6	19	18.3	26	22.2	13	18.0	39	20.6
Total	56	100.0	29	100.0	85	100.0	61	100.0	43	100.0	104	100.0	117	100.0	72	100.0	189	100.0

Appendix Table 4.39

Complication of mother within first fortnight of delivery as reported by mothers according to location and training status of dais attending on them

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Complications during latest delivery																		
None	213	90.6	99	91.7	312	91.0	185	95.4	153	95.0	338	95.2	398	92.8	252	93.7	650	93.1
Fever	12	5.1	5	4.6	17	5.0	7	3.6	5	3.1	12	3.4	19	4.4	10	3.7	29	4.1
PPH	6	2.5	-	-	6	1.7	-	-	-	-	-	-	6	1.4	-	-	6	0.9
Fever + PPH	-	-	1	0.9	1	0.3	1	0.5	2	1.2	3	0.8	1	0.2	3	1.1	4	0.6
Others	4	1.7	3	2.8	7	2.0	1	0.5	1	0.6	2	0.6	5	1.2	4	1.5	9	1.3
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0
Complications during earlier delivery																		
None	45	80.4	26	89.7	71	83.5	52	85.2	36	83.7	88	84.6	97	82.9	62	86.1	159	84.1
Fever	-	-	-	-	-	-	1	1.6	1	2.3	2	1.9	1	0.8	1	1.4	2	1.1
PPH	1	1.8	-	-	1	1.2	-	-	-	-	-	-	1	0.8	-	-	1	0.5
Can't say	10	18.0	3	10.3	13	15.3	8	13.1	6	14.0	14	13.5	18	15.4	9	12.5	27	14.3
Total	56	100.0	29	100.0	85	100.0	61	100.0	43	100.0	104	100.0	117	100.0	72	100.0	189	100.0

Appendix Table 4.40

Action taken by dai for fever and PPH during latest pregnancy as reported by mothers according to location and training status of dais attending on them

tion taken r fever	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
d not have ver/no com- ications	223	94.9	103	95.4	326	95.0	186	95.9	154	95.6	340	95.8	409	95.3	257	95.5	666	95.4
action	1	0.4	1	0.9	2	0.6	-	-	-	-	-	-	1	0.2	1	0.4	2	0.3
led for F)/ANM	1	0.4	-	-	1	0.3	1	0.5	-	-	1	0.3	2	0.5	-	-	2	0.3
ferred to PHC	1	0.4	-	-	1	0.3	2	1.0	-	-	2	0.6	3	0.7	-	-	3	0.4
erred to vate doctor	4	1.7	2	1.8	6	1.7	2	1.0	2	1.2	4	1.1	6	1.4	4	1.5	10	1.4
r not re- ted to dai	5	2.1	2	1.8	7	2.0	3	1.5	5	3.2	8	2.2	8	1.9	7	2.6	15	2.1
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0

...Contd.197

Appendix Table 4.40 (Contd.)

Action taken for PPH	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Did not have PPH/no complications	229	97.4	103	100.0	337	98.2	193	99.5	159	98.8	352	99.1	422	98.4	267	99.3	689	98.7
No action	2	0.8	-	-	2	0.6	-	-	-	-	-	-	2	0.5	-	-	2	0.3
Called for FW(F)/ANM	2	0.8	-	-	2	0.6	-	-	-	-	-	-	2	0.5	-	-	2	0.3
Referred to private doctor	-	-	-	-	-	-	1	0.5	-	-	1	0.3	1	0.2	-	-	1	0.1
PPH not reported to dai	2	0.8	-	-	2	0.6	-	-	2	1.2	2	0.6	2	0.5	2	0.7	4	0.6
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	693	100.0

.....198

Appendix Table 4.41

Number of days of follow up to mothers after delivery as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
follow-r	-	-	-	-	-	-	-	-	1	3.5	1	1.5	-	-	1	2.0	1	0.8
e day	1	2.4	-	-	1	1.6	2	5.3	1	3.5	3	4.5	3	3.8	1	2.0	4	3.1
o days	1	2.4	1	4.8	2	3.2	1	2.6	1	3.5	2	3.0	2	2.5	2	4.0	4	3.1
ee days	-	-	-	-	-	-	1	2.6	2	6.9	3	4.5	1	1.2	2	4.0	3	2.3
r days	-	-	-	-	-	-	2	5.3	1	3.5	3	4.5	2	2.5	1	2.0	3	2.3
e days	4	9.5	5	23.8	9	14.3	7	18.4	4	13.8	11	16.4	11	13.7	9	18.0	20	15.4
x days	1	2.4	-	-	1	1.6	-	-	1	3.5	1	1.5	1	1.2	1	2.0	2	1.5
en +	35	83.3	15	71.4	50	79.4	25	65.8	18	62.1	43	64.2	60	75.0	33	66.0	93	71.5
otal	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....199

Appendix Table 4.42

Number of days of follow up to new born as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No follow-up	-	-	-	-	-	-	-	-	1	3.5	1	1.5	-	-	1	2.0	1	0.8
One day	1	2.4	-	-	1	1.6	2	5.3	1	3.5	3	4.5	3	3.8	1	2.0	4	3.1
Two days	1	2.4	1	4.8	2	3.2	1	2.6	1	3.5	2	3.0	2	2.5	2	4.0	4	3.1
Three days	-	-	-	-	-	-	1	2.6	2	6.9	3	4.5	1	1.2	2	4.0	3	2.3
Four days	-	-	-	-	-	-	2	5.3	1	3.5	3	4.5	2	2.5	1	2.0	3	2.3
Five days	4	9.5	5	23.6	9	14.3	7	18.4	4	13.8	11	16.4	11	13.7	9	18.0	20	15.4
Six days	1	2.4	-	-	1	1.6	-	-	1	3.5	1	1.5	1	1.2	1	2.0	2	1.5
Seven +	35	83.3	15	71.4	50	79.4	25	65.8	18	62.1	43	64.2	60	75.0	33	66.0	93	71.5
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....200

Appendix Table 4.43

Specific care provided to mothers as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Control PPH	21	50.0	13	61.9	34	54.0	21	55.3	15	51.8	36	53.8	42	52.5	28	56.0	70	53.8
Washing dirty clothes	3	7.2	3	14.3	6	9.6	2	5.3	5	17.3	7	10.5	5	6.2	8	16.0	13	10.0
Oil massage	13	31.0	6	28.7	19	30.2	11	28.9	10	34.6	21	29.9	24	30.0	16	32.0	40	30.8
Give hot waterbath	12	28.6	4	19.1	16	25.4	11	28.9	12	41.3	23	34.4	23	28.7	16	32.0	39	30.0
Controlled diet	3	7.2	-	-	3	4.8	2	5.3	-	-	2	3.0	5	6.2	-	-	5	3.8
Breast feeding	13	31.0	8	38.1	21	33.4	9	23.7	8	27.6	17	25.4	22	27.5	16	32.0	38	29.2
Care of perinium	-	-	-	-	-	-	3	7.8	1	3.5	4	6.0	3	3.7	1	2.0	4	3.1
Check for abdominal pain	9	21.4	7	33.3	16	25.4	6	15.8	6	20.7	12	17.9	15	18.7	13	36.0	28	21.5

.....Contd. 201

Appendix Table 4.43 (Contd.)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Personal hygiene	2	4.8	1	4.8	3	4.8	-	-	1	3.5	1	1.5	2	2.5	2	4.0	4	3.1
Use of antiseptic lotion	1	2.4	-	-	1	1.6	-	-	-	-	-	-	1	1.2	-	-	1	0.8
Use of pads	2	4.8	-	-	2	3.2	-	-	2	7.0	2	3.0	2	2.5	2	4.0	4	3.1
Herbal medication	4	9.5	2	9.6	6	9.5	4	10.5	5	17.3	9	13.3	8	10.0	7	14.0	15	11.5
General health	20	47.6	8	38.1	28	44.5	24	63.1	13	44.7	37	55.3	44	55.0	21	42.0	65	50.0
Can't say	1	2.4	3	14.4	4	6.3	-	-	-	-	-	-	1	1.2	3	6.0	4	3.1

NOTE: Multiple response

.....202

Appendix Table 4.44

Specific care provided to new-born as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
are of cord	22	52.4	9	43.0	31	49.3	14	36.8	15	51.6	29	43.3	36	45.0	24	48.0	60	46.2
l massage	8	19.1	6	28.6	14	22.2	10	26.3	8	27.6	18	26.9	18	22.5	14	28.0	32	24.6
t bath	14	33.3	6	28.6	20	31.8	13	34.2	14	48.2	27	40.5	27	33.7	20	40.0	47	36.1
ply ghee/ l etc.to rd	13	31.0	6	28.6	19	30.2	14	36.8	7	24.1	21	31.3	27	33.7	13	26.0	40	30.8
hedule for east feed	11	26.2	10	47.7	21	33.3	12	31.6	9	31.1	21	31.3	23	28.7	19	38.0	42	32.3
ve sugar ter	-	-	-	-	-	-	2	5.3	-	-	2	3.0	2	2.5	-	-	2	1.5
re of eyes	-	-	1	4.8	1	1.6	-	-	-	-	-	-	-	-	1	2.0	1	0.8
mentation th hing etc	2	4.8	1	4.8	3	4.8	2	5.3	-	-	2	3.0	4	5.0	1	2.0	5	3.8
eck passing urine/stool	1	2.4	-	-	1	1.6	1	2.6	-	-	1	1.5	2	2.5	-	-	2	1.5
sh clothes	2	4.8	-	-	2	3.2	2	5.3	4	13.8	6	9.0	4	5.0	4	8.0	8	6.1
neral health	23	54.7	7	33.4	30	47.6	19	50.0	18	62.1	37	55.2	42	52.5	25	50.0	67	51.5
n't say	-	-	3	14.4	3	4.8	-	-	1	3.5	1	1.5	-	-	4	8.0	4	3.1

NOTE : Multiple response.

Appendix Table 4.45

Satisfaction with the services of dai as reported by mothers according to location and training status of dais attending on them

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Satisfied	234	99.6	107	99.1	341	99.4	194	100.0	159	98.8	353	99.4	428	99.8	266	98.9	694	99.4
Not satisfied	1	0.4	1	0.9	2	0.6	-	-	2	1.2	2	0.6	1	0.2	3	1.1	4	0.6
	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0

.....204

Appendix Table 4.46

Reasons for satisfaction with dais services as reported by mothers according to location and training status of dais attending on them

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
satisfied	1	0.4	1	0.9	2	0.6	-	-	2	1.2	2	0.6	1	0.2	3	1.1	4	0.6
ks after nerly	2	0.8	-	-	2	0.6	1	0.5	1	0.6	2	0.6	3	0.7	1	0.4	4	0.6
lful/ icient	38	16.2	25	23.1	62	18.1	31	16.0	33	20.5	64	18.0	69	16.1	58	21.6	127	18.2
essible	128	54.5	53	49.1	181	52.8	102	52.6	75	46.6	177	49.9	230	53.6	128	47.6	358	51.3
ated to ily	1	0.4	1	0.9	2	0.6	2	1.0	1	0.6	3	0.8	3	0.7	2	0.7	5	0.7
dai in age	8	3.4	5	4.6	13	3.8	-	-	3	1.9	3	0.8	8	1.9	8	3.0	16	2.3
best she can	-	-	1	0.9	1	0.3	-	-	1	0.6	1	0.3	-	-	2	0.7	2	0.3
is trained	1	0.4	-	-	1	0.3	-	-	2	1.2	2	0.6	1	0.2	2	0.7	3	0.4
erative	1	0.4	1	0.9	2	0.6	1	0.5	4	2.5	5	1.4	2	0.5	5	1.9	7	1.0
lar	1	0.4	-	-	1	0.3	-	-	3	1.9	3	0.8	1	0.2	3	1.1	4	0.6
ks & ad- s regularly	3	1.3	-	-	3	0.9	1	0.5	-	-	1	0.3	4	0.9	-	-	4	0.6
utes nicely	49	20.8	20	18.5	69	20.1	53	27.3	33	20.5	86	24.2	102	23.8	53	19.7	155	22.2
ages well	2	0.8	1	0.9	3	0.9	-	-	3	1.9	3	0.8	2	0.5	4	1.4	6	0.9
t say	-	-	-	-	-	-	3	1.0	-	-	3	0.8	3	0.5	-	-	3	0.4
otal	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0

Appendix table 5.1

Number of years of acquaintance with dai as reported by mothers according to location and Training status of dais attending on them

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.		No.		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
One year	5	2.1	3	2.8	8	2.3	2	1.0	3	1.9	5	1.4	7	1.6	6	2.2	13	1.9
Two years	9	3.8	4	3.7	13	3.8	4	2.1	9	5.6	13	3.7	13	3.0	13	4.8	26	3.7
Three yrs.	7	3.0	5	4.6	12	3.5	7	3.6	7	4.3	14	3.9	14	3.3	12	4.5	26	3.7
Four yrs.	3	1.3	1	0.9	4	1.2	4	2.1	3	1.9	7	2.0	7	1.6	4	1.5	11	1.6
Five yrs.	48	20.4	19	17.6	67	19.5	36	18.6	29	18.0	65	18.3	84	19.6	48	17.8	132	18.9
Six yrs.	6	2.6	8	7.4	14	4.1	14	7.2	6	3.7	20	5.6	20	4.7	14	5.2	34	4.9
Seven yrs plus	157	66.8	68	63.0	225	65.6	127	65.5	104	64.6	231	65.1	284	66.2	172	63.9	456	65.3
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0

.....206

Appendix Table 5.2

Amount paid in cash to dai for her services during latest delivery as reported by mothers according to location and training status of dais attending on them

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Nil	116	49.4	62	57.4	178	51.9	106	54.6	99	61.5	205	57.7	222	51.7	161	59.8	383	54.9
Rs.1-2	23	9.8	11	10.2	34	9.9	14	7.2	14	8.7	28	7.9	37	8.6	25	9.3	62	8.9
Rs.3-5	36	15.3	12	11.1	48	14.0	20	10.3	11	6.8	31	8.7	56	13.0	23	8.5	79	11.3
Rs.6-10	34	14.5	9	8.3	43	12.5	31	16.0	16	9.9	47	13.2	65	15.1	25	9.3	90	12.9
Rs.11-15	12	5.1	5	4.6	17	5.0	17	8.8	10	6.2	27	7.6	29	6.8	15	5.6	44	6.3
Rs.16-20	7	3.0	2	1.8	9	2.6	2	1.0	4	2.5	6	1.7	9	2.1	6	2.2	15	2.1
Rs.20-25	3	1.3	5	4.6	8	2.3	3	1.5	4	2.5	7	2.0	6	1.4	9	3.3	15	2.1
Rs.25+	3	1.3	2	1.8	5	1.6	1	0.5	3	1.9	4	1.1	4	0.9	5	1.9	9	1.3
Can't say	1	0.4	-	-	1	0.3	-	-	-	-	-	-	1	0.2	-	-	1	0.1
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0

.....207

Appendix Table 5.3

Amount paid in cash to dai for her services in previous delivery as reported by mothers according to location and training status of dais attending on them

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Nil	22	39.3	17	58.6	39	45.9	31	50.8	26	60.5	57	54.8	53	45.3	43	59.7	96	50.8
Rs. 1 to 2	8	14.3	1	3.4	9	10.6	5	8.2	-	-	5	4.8	13	11.1	1	1.4	14	7.4
Rs. 3 to 5	9	16.1	3	10.3	12	14.1	2	3.3	2	4.6	4	3.8	11	9.4	5	6.9	16	8.5
Rs. 6 to 10	5	8.9	2	6.9	7	8.2	9	14.7	5	11.6	14	13.5	14	12.0	7	9.7	21	11.1
Rs.11 to 15	1	1.8	1	3.4	2	2.4	7	11.5	5	11.6	12	11.5	8	6.8	6	8.3	14	7.4
Rs.16 to 20	1	1.8	-	-	1	1.2	1	1.6	1	2.3	2	1.9	2	1.7	1	1.4	3	1.6
Rs.20 to 25	2	3.6	-	-	2	2.4	-	-	2	4.6	2	1.9	2	1.7	2	2.8	4	2.1
Can't say	8	14.3	5	17.2	13	15.3	6	9.8	2	4.6	8	7.7	14	12.0	7	9.7	21	11.1
Total	56	100.0	29	100.0	85	100.0	61	100.0	43	100.0	104	100.0	117	100.0	72	100.0	189	100.0

.....208

Appendix Table 5.4

Amount paid in kind for dais services during latest pregnancy as reported by mothers according to location and training status of dais attending on them

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Nil	114	48.5	51	47.2	165	48.1	88	45.4	60	37.3	148	41.7	202	47.1	111	41.3	313	44.8
Clothes	6	2.5	4	3.7	10	2.9	8	4.1	8	5.0	16	4.5	14	3.3	12	4.5	26	3.7
Foodgrains	53	22.5	23	21.3	76	22.2	33	17.0	37	23.0	17	19.7	86	20.0	60	22.3	146	20.9
Ornaments	30	12.8	18	16.6	48	14.0	43	22.2	29	18.0	72	20.3	73	17.0	47	17.5	120	17.2
Clothes + foodgrains	10	4.3	6	5.6	16	4.7	1	0.7	4	2.5	5	1.4	11	2.6	10	3.7	21	3.0
Clothes + ornaments	10	4.3	4	3.7	14	4.1	16	8.2	19	11.8	35	9.8	26	6.1	23	8.6	49	7.0
Foodgrains + ornaments	8	3.4	2	1.8	10	2.9	1	0.9	3	1.9	4	1.1	9	2.1	5	1.9	14	1.0
Foodgrains + utensils	-	-	-	-	-	-	-	-	1	0.6	1	0.3	-	-	1	0.4	1	0.1
Clothes + foodgrains + ornaments	3	1.3	-	-	3	0.9	3	1.5	-	-	3	0.8	6	1.4	-	-	6	0.9
Can't say	1	0.4	-	-	1	0.3	1	0.5	-	-	1	0.3	2	0.5	-	-	2	0.3
Total	235	100.0	108	100.0	343	100.0	194	100.0	161	100.0	355	100.0	429	100.0	269	100.0	698	100.0

Appendix Table 5.5

Amount paid in kind for dais services during previous pregnancy as reported by mothers according to location and training status of dais attending on them

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Nil	26	46.4	15	51.7	41	48.2	29	47.5	21	48.8	50	48.1	55	47.0	36	50.0	91	48.1
Clothes	1	1.8	1	3.4	2	2.3	3	4.9	2	4.6	5	4.8	4	3.4	3	4.2	7	3.7
Foodgrains	11	19.6	2	6.9	13	15.3	11	18.0	3	7.0	14	13.5	22	18.8	5	6.9	27	14.3
ornaments	3	5.4	3	10.3	6	7.1	5	8.2	7	16.3	12	11.5	8	6.8	10	13.9	18	9.5
Clothes + foodgrains	3	5.4	3	10.3	6	7.1	-	-	-	-	-	-	3	2.6	3	4.2	6	3.2
Clothes + ornaments	1	1.8	1	3.4	2	2.3	4	6.6	7	16.3	11	10.6	5	4.3	8	11.1	13	6.9
Foodgrains + utensils	1	1.8	-	-	1	1.2	1	1.6	2	4.6	3	2.9	2	1.7	2	2.8	4	2.1
Clothes + foodgrains + ornaments	2	3.6	-	-	2	2.3	1	1.6	-	-	1	1.0	3	2.6	-	-	3	1.6
Don't know/ Can't say	8	14.3	4	13.8	12	14.1	7	11.5	1	2.3	8	7.7	15	12.8	5	6.9	20	10.6
Total	56	100.0	29	100.0	85	100.0	61	100.0	43	100.0	104	100.0	117	100.0	72	100.0	189	100.0

.....210

Appendix Table 5.6

Categories of health functionaries contacted as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
one	2	4.8	3	14.3	5	7.9	18	47.4	17	58.6	35	52.2	20	25.0	20	40.0	40	30.8
N(F)/ANM	32	76.2	11	52.4	43	68.2	16	42.1	10	34.5	26	38.8	48	60.0	21	42.0	69	53.1
A(F)/LHV	6	14.3	4	19.0	10	15.9	4	10.5	2	6.9	6	9.0	10	12.5	6	12.0	16	12.3
N(M)	2	4.8	-	-	2	3.2	-	-	-	-	-	-	2	2.5	-	-	2	1.5
an't say	-	-	3	14.3	3	4.8	-	-	-	-	-	-	-	-	3	6.0	3	2.3
otal	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....211

Appendix Table 5.7

Purpose of contact with health worker as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
o contact	2	4.8	3	14.3	5	7.9	18	47.4	17	58.6	35	52.2	20	25.0	20	40.0	40	30.8
ecn. of ANC NC cases	11	26.2	5	20.5	16	25.4	3	7.9	1	3.4	4	6.0	14	17.5	6	12.0	20	15.4
or getting others checked	5	11.9	1	4.8	6	9.5	2	5.3	3	10.3	5	7.5	7	8.7	4	8.0	11	8.5
or getting others immu-ized	8	19.0	-	-	8	12.7	2	5.3	2	6.9	4	6.0	10	12.5	2	4.0	12	9.2
or getting F tablets	2	4.8	-	-	2	3.2	-	-	1	3.4	1	1.5	2	2.5	1	2.0	3	2.3
or showing complicated ases	3	7.1	-	-	3	4.8	-	-	-	-	-	-	3	3.7	-	-	3	2.3
or prepara-ion of home onfinement	1	2.4	-	-	1	1.6	1	2.6	-	-	1	1.5	2	2.5	-	-	2	1.5
or managing ifficult labor	16	38.1	2	9.5	18	28.6	6	15.8	3	10.3	9	13.4	22	27.5	5	10.0	27	20.8
or referring complicated ases	1	2.4	-	-	1	1.6	-	-	1	3.4	1	1.5	1	1.2	1	2.0	2	1.5
or FP cases	3	7.1	4	19.1	7	11.1	-	-	1	3.4	1	1.5	3	3.7	5	10.0	8	6.1
or reporting irths & deaths	8	19.1	3	14.3	11	17.5	8	21.0	2	6.9	10	14.9	16	20.0	5	10.0	21	16.2
thers	4	9.5	2	9.5	6	9.5	-	-	-	-	-	-	4	5.0	2	4.0	6	4.6

NOTE : Multiple response

.....212

Appendix Table 5.8

Type of help rendered to health workers as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
help	8	19.0	9	42.9	7	27.0	21	55.3	20	69.0	41	61.2	29	36.3	29	58.0	58	44.6
Regn. of C cases	16	38.1	5	23.8	21	33.3	5	13.2	4	13.8	9	13.4	21	26.2	9	18.0	30	23.1
immuniza-on camps	13	31.0	4	19.0	17	27.0	3	7.9	4	13.8	7	10.4	16	20.0	8	16.0	24	18.5
distribu-ng IFS tabs	4	9.5	1	4.8	5	7.9	-	-	2	6.9	2	3.0	4	5.0	3	6.0	7	5.4
conducting liveries	13	30.9	2	9.5	15	23.8	5	13.2	2	6.9	7	10.4	18	22.5	4	8.0	22	16.9
oviding PNC re to mothers	1	2.4	-	-	1	1.6	-	-	1	3.4	1	1.5	1	1.2	1	2.0	2	1.5
gn. of births deaths	9	21.5	2	9.5	11	17.5	6	15.8	-	-	6	9.0	15	18.7	2	4.0	17	13.1
FP camps	9	21.5	2	9.5	11	17.5	1	2.6	1	3.4	2	3.0	10	10.2	3	6.0	13	10.0

NOTE: Multiple response

.....213

Appendix Table 5.9

Liking to work with health workers as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total			
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Liked to work	33	78.6	13	61.9	46	73.0	1	2.6	-	-	1	1.5	34	42.5	13	26.0	47	36.2
Do not like to work	9	21.4	7	33.3	16	25.4	25	65.8	18	62.1	43	6422	34	42.5	25	50.0	59	45.4
Can't say	-	-	1	4.8	1	1.6	12	31.6	11	37.9	23	34.3	12	15.0	12	24.0	24	18.4
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....214

Appendix Table 5.10

Reasons for likeing to function with health workers as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
n't like to work	9	21.4	7	33.3	16	25.4	25	65.8	18	62.1	43	64.2	34	42.5	25	50.0	59	45.4
r getting thers checked	1	2.4	1	4.8	2	3.2	1	2.6	-	-	1	1.5	2	2.5	1	2.0	3	2.3
r getting unization	-	-	-	-	-	-	1	2.6	-	-	1	1.5	1	1.2	-	-	1	0.8
r regn. of cases	1	2.4	-	-	1	1.6	-	-	-	-	-	-	1	1.2	-	-	1	0.8
tends to fficult case	2	4.8	-	-	2	3.2	3	7.9	4	13.7	7	10.4	5	6.2	4	8.0	9	6.9
od natured	5	11.9	2	9.5	7	11.1	-	-	-	-	-	-	5	6.2	2	4.0	7	5.4
ns in eco- ic matters	1	2.4	1	4.8	2	3.2	-	-	1	3.4	1	1.5	1	1.2	2	4.0	3	2.3
ns in atte- ng to plicated ses	3	7.1	2	9.5	5	7.9	4	10.5	5	17.2	9	13.4	7	8.7	7	14.0	14	10.8
n't say	20	47.6	8	38.1	28	44.4	4	10.5	1	3.4	5	7.5	24	30.0	9	18.0	33	25.4
otal	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

Appendix Table 5.11

Reasons for not liking to work with health workers as reported by dais according to location and training status

	Trained Dai						Untrained Dai						Total					
	PHC/SC		Remote		Total		PHC/SC		Remote		Total		PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Like to work	33	78.6	13	61.9	46	73.0	1	2.6	-	-	1	1.5	34	42.5	13	26.0	47	36.2
Inaccessible	-	-	-	-	-	-	-	-	3	10.3	3	4.5	-	-	3	6.0	3	2.3
Interferes in profession	1	2.4	-	-	1	1.6	1	2.6	-	-	1	1.5	2	2.5	-	-	2	1.5
Too old	2	4.8	1	4.8	3	4.8	4	10.5	3	10.3	7	10.4	6	7.5	4	8.0	10	7.7
Can manage myself	-	-	-	-	-	-	1	2.6	-	-	1	1.5	1	1.2	-	-	1	0.8
Fear of loss of cases	-	-	1	4.8	1	1.6	-	-	-	-	-	-	-	-	1	2.0	1	0.8
HWs are more educated	1	2.4	-	-	1	1.6	-	-	-	-	-	-	1	1.2	-	-	1	0.8
Domestic problems	5	11.9	6	28.6	11	17.5	6	15.8	5	17.2	11	16.4	11	13.7	11	22.0	22	16.9
Can't say	-	-	-	-	-	-	25	65.8	18	62.1	43	64.2	25	31.3	18	36.0	43	55.9
Total	42	100.0	21	100.0	63	100.0	38	100.0	29	100.0	67	100.0	80	100.0	50	100.0	130	100.0

.....216

Appendix Table 5.12

Time of receipt of stipend as reported by dais according location

	PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%
Immediately after trg.	2	4.8	-	-	2	3.2
Within a month	8	19.1	3	14.3	11	17.5
After a month	16	38.1	10	47.6	26	41.3
After three months	16	38.1	7	33.3	23	36.5
Can't say	-	-	1	4.8	1	1.6
Total	42	100.0	21	100.0	63	100.0

Appendix Table 5.13

Remuneration received for registering ANC cases as reported by trained dais according to location

	PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%
Nil	31	73.8	15	71.4	46	73.0
Rs. two	8	19.1	2	9.5	10	15.9
Rs. Three	3	7.1	2	9.5	5	7.9
Rs. Four	-	-	1	4.8	1	1.6
Can't say	-	-	1	4.8	1	1.6
Total	42	100.0	21	100.0	63	100.0

.....217

Appendix Table 5.14

Suggestions given by trained dais for improvement of Training Programme according to location

	PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%
None	21	50.0	6	28.6	27	42.8
Provision of full-time service to trd. dais	13	31.0	7	33.3	20	31.7
Timely disbursal of stipend and kits	3	7.2	1	4.8	4	6.3
Need for follow-up by health staff	1	2.4	1	4.8	2	3.1
Training period be increased	1	2.4	2	9.5	3	4.8
Stipend be increased	1	2.4	-	-	1	1.6
More new techniques be taught	1	2.4	5	23.8	6	9.5
Techniques regarding handling complicated cases be taught	2	4.8	-	-	2	3.1

Note: Multiple response

Appendix Table 5.15

Duration of further training as reported by trained dais according to location

	PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%
No need	21	50.0	9	42.9	30	47.6
8-15 days	2	4.8	3	14.3	5	7.9
24-30 days	10	23.8	3	14.3	13	20.6
1 - 2 months	2	4.8	3	14.3	5	7.9
2 - 3 months	2	4.8	-	-	2	3.2
3 months +	3	7.1	1	4.8	4	6.4
Can't say	2	4.8	2	9.5	4	6.4
Total	42	100.0	21	100.0	63	100.0

Appendix Table 5.16

Topics to be included in the retraining programme as suggested by trained dais according to location

	PHC/SC		Remote		Total	
	No.	%	No.	%	No.	%
No need of retraining	21	50.0	9	42.9	30	47.6
Aseptic techniques	-	-	1	4.8	1	1.6
Immunization	-	-	1	4.8	1	1.6
Managemnt of difficult labour	10	23.8	5	23.8	15	23.8
Sterilization of instrument	-	-	1	4.8	1	1.6
Care of new born	2	4.8	-	-	2	3.2
Family Planning	1	2.4	1	4.8	2	3.2
Nutrition of mother and baby	1	2.4	-	-	1	1.6
Repeat the present course again	6	14.3	3	14.3	9	14.3
More supervised deliveries	1	2.4	-	-	1	1.6
To get part-time job	1	2.4	1	4.8	2	3.2
Others	-	-	2	9.6	2	3.2
Can't say	9	21.3	6	28.5	15	23.7

Note: Multiple response

Appendix Table 5.17

Need for retraining as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Retraining needed	10	76.9	1	100.0	11	78.6
Retraining not needed	3	23.1	-	-	3	21.4
Total	13	100.0	1	100.0	14	100.0

Appendix Table 5.18

Time-space between present training and the further training as reported by trainers according to location

	ANM/PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
After one year	4	30.8	-	-	4	28.6
After two years	1	7.7	-	-	1	7.1
After three years	-	-	1	100.0	1	7.1
Can't say	8	61.5	-	-	8	57.1
Total	13	100.0	1	100.0	14	100.0

Appendix Table 5.19

Place of retraining as suggested by trainers according to location

	ANM/PHC		ANM sc		Total	
	No.	%	No.	%	No.	%
PHC headquarters	9	69.2	1	100.0	10	71.4
In dais' villages	1	7.7	-	-	1	7.1
Can't say	3	23.1	-	-	3	21.4
Total	13	100.0	1	100.0	14	100.0

Appendix Table 5.20

Topics of retraining as suggested by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
ANC/PNC care	-	-	1	100.0	1	7.1
Conduct of normal delivery	8	61.5	-	-	8	57.1
Others	1	7.7	-	-	1	7.1
Can't say	4	30.8	-	-	4	28.6
Total	13	100.0	1	100.0	14	100.0

.....220

Appendix Table 5.21

Duration of retraining as suggested by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
1 - 7 days	1	7.7	-	-	1	7.1
8 - 15 days	5	38.5	-	-	5	35.7
23 - 30 days	3	23.1	-	-	3	21.4
2 - 3 months	1	7.7	-	-	1	7.1
Can't say	3	23.1	1	100.0	4	28.6
Total	13	100.0	1	100.0	14	100.0

Appendix Table 5.22

Retraining programme conducted as reported by trainers according to location

	ANM PHC		ANM SC		Total	
	No.	%	No.	%	No.	%
Retraining programme conducted	2	15.4	-	-	2	14.3
Retraining programme not conducted	11	84.6	1	100.0	12	85.7
Total	13	100.0	1	100.0	14	100.0

****

SURVEY INSTRUMENTS

DEQ - 1

INDIAN INSTITUTE OF MANAGEMENT, BANGALORE

in Collaboration with

NATIONAL INSTITUTE OF HEALTH AND FAMILY WELFARE, NEW DELHI

(MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA)

EVALUATION OF DAI TRAINING SCHEME 1980

INTERVIEW SCHEDULE FOR DAI

Schedule No | | | | | Village in which she practices

State _____

District _____

P.H.C. _____

Village of residence _____

Type of village _____

1. P.H.C. Village [ ]
2. Sub-Centre Village [ ]
3. Other 5 K.M. remote village [ ]

1. Name of Dai _____
2. Age in years _____
3. Marital Status | U | M | D | W |
4. No. of living children (if ever married) _____
5. Education Status:

   Illiterate [ ] Primary [ ]

   Literate [ ] Above Primary [ ]
6. Religion | H | M | S | CHR |
7. Caste (Specify) _____
8. Vication/Occupation:

   1. Main _____

   2. Secondary _____
9. Husband/Father's Occupation _____
10. Monthly income of family from all sources (as stated) _____

11. Is it your family vocation to work as a Dai? Yes/No

If no, who introduced you to practice as a Dai?

1. Self ☐
2. Clore Relations ☐
3. Village Dai ☐
4. Health Worker ☐
5. Any other (Specify) _____

12. How did you learn to work as a Dai? _____

13. Training status:

1. Untrained ☐ 2. Trained ☐

If trained, month and year of training _____

14. For how long you are working as a Dai? _____ (in yrs.)

15. Generally which category of health functionary of the centre you contact?

1. H.W.(F)/A.N.M. ☐
2. H.A.(F)/L.H.V. ☐
3. H.W.(M) ☐
4. B.E.E./H.A.(M) ☐
5. None ☐

16. What for you have been contacting them?

1. _____
2. _____
3. _____

17. As a Dai what help you have been rendering to the H.W.(F)/A.N.M. of your area?

1. _____
2. _____
3. _____
4. _____

18. Did you like to work along with H.W.(F)/A.N.M. of your area? Yes/No

If No, state reasons:

1. _____
2. _____
3. _____

19. How many expecting mothers you have contacted during the past 3 months?

_____ Nos.

(If to Q.19 answer is Nil skip to Q. 21)

20. Generally regarding what you give advice to expecting mothers:

(ANSWERS NOT TO BE READ)

1. Registration at S.C. ☐
2. Regular check-up at S.C./P.H.C. ☐
3. Immunization (T.T.) ☐
4. Nutrition for mother ☐
5. Preparation for confinement ☐
6. Prophylaxis against nutritional anaemia ☐
7. Family Planning ☐
8. Personal hygiene ☐
9. Any other (specify) ☐

21. In the last 3 months, how many deliveries core conducted by you?

1. Total _____ Nos.
2. Yourself _____ Nos.
3. Alongwith H.W.(F)/ANM _____ Nos.

22. Give the details of five mothersrecently delivered by you:

Name	Address with the name of Head of the Family	Approximate month & year of delivery
1.		
2.		
3.		
4.		
5.		

23. Out of the deliveries conducted by you in Q. No. 21, how many mothers:

1. Registered at Sub-Centre _____ Nos.

2. Received atleast 3 doses of T.T. _____ Nos.

3. Received prophylaxis against nutritional anaemia _____ Nos.

4. Had new born babies:

i. Living _____ Nos.

ii. Who dief _____ Nos.

(In case of those babies who died)

Cause of Death	Ages at Death
1.	
2.	
3.	
4.	

5. No: of babies who had septic umbilicus _____ Nos.

6. No. of mothers who suffered with fever within first 10 days _____ Nos.

24. With what do you cut the cord?

1. Scissor ☐ 3. Sickle ☐

2. Blade ☐ 4. Any other (specify) _____

25. Do you boil it? Yes/No

a. If yes, why? 1. _____

2. _____

3. _____

b. and for how long? _____ minutes

26. How do you prevent sepsis in:

a. Mothers: 1. _____

2. _____

3. _____

4. _____

b. Babies: 1. _____

2. _____

3. _____

4. _____

27. Did you advise these mothers for Family Planning? Yes/No

If no, why not? 1. _____

2. _____

3. _____

4. _____

28. How many cases you have been able to persuade for acceptance of following Family Planning methods in the last 3 months?

Methods	Number of cases who accepted
1. Nirodh	
2. Oral Pills	
3. I.U.D.	
4. Sterilisation	
5. M.T.P.	

29. Do you think that babies should be immunised? Yes/No

If yes, why?

30. How do you arrange for immunisation of babies delivered by you?

1. Inform Health Workr ☐
2. Advisemothers to attend clinic ☐
3. Accompany mothers on clinic day ☐
4. Any other (Specify) _____

31. Do you later on enquire from the families whether the immunisation has been given to babies? Yes/No

If No, why? _____

_____

32. For how many days you provide care:

1. to mother after delivery? _____ Days
2. to new born babies? _____ Days

33. What specific care you provide for first 3 days after delivery to:

a. Mothers: 1. _____
2. _____
3. _____

b. Babies: 1. _____
2. _____
3. _____

34. Under what conditions do you seek help from H.W.(F)/A.N.M./H.A.(F)/ L.H.V. for post natal care? _____

_____

35. During last 3 months, how many cases did you refer to:

	Number of Cases
i. Sub-centre	
ii. P?H.C./Hospital	
iii. Private doctor	

(TO BE ASKED FROM TRAINED DAIS ONLY)

36. How did you come to know about Dai Training?(specify the source of information) _____

37. Who motivated you to undergo this training?

(ANSWERS NOT TO BE READ)

- Trained Dai ☐
- H.W.(F)./A.N.M. ☐
- Other health staff at PHC ☐
- Community Leaders ☐
- Self ☐
- Any other (specify)_____

38. With what expectations did you undertake this training?

(ANSWERS NOT TO BE READ)

- For economic benefits ☐
- To get stipend money ☐
- To get the maternity kit ☐
- To have closer contacts with PHC staff and sub-centre staff ☐
- To learn improved midwifery practices ☐
- To manage difficult labour cases ☐
- To learn techniques to IUD insertion and termination of pregnancy ☐
- To gain higher status in the community ☐
- To learn to workas a Dai ☐
- Any other (specify) _____

39. How many weeks did you come for the Training? _____Weeks

40. How many days did you attend the following during your training?

	Daily	Twice a week	Thrice a week	4 days a week
a. Class				
b. Home visiting				
c. Clinic at Sub-Centre/ P.H.C.				

41. During training how many deliveries were conducted by you?

1. Total _____ Nos.
2. Independently _____ Nos.
3. With ANM/HW(F) _____ Nos.

42. What are the various areas that were discussed by your trainer during training?

	Explained	Practical Demonstration	Did not teach
1. Need for registration			
2. Regular check-up and testings			
3. Anatomy of female organs			
4. Aseptic techniques			
5. Managing normal labour			
6. Alarming signs and symptoms during pregnancy			
7. Need for referral			
8. Preparation for home confinement			
9. Care of Perineum			
10. Care of Breast			
11. Care of new born			
12. Care of Cord			
13. Family poanning methods and their role			
14. Reporting Births and Deaths			
15. Nutrition for mother and baby			
16. Need for immunisation of mothers/new borns			

43. During your training were you demonstrated:

a. To test urine for:

i. Albumin Yes/No

ii. Sugar Yes/No

c. Demonstrated/observed family Planning methods such as:

1. Filling Applicator with Jelly Yes/No

b. Prepare and give anema to mothers Yes/No

2. Foam Tablets Yes/No

44. What improved midwifery practices you were taught of which you were not aware before training?

1. _____
2. _____
3. _____

45. What contents of the Maternity Kit were demonstrated to you during training?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

46. Were you demonstrated how to use the Maternity Kit while conducting labour cases? Yes/No

47. Did you get an apportunity to sterilise the kit equipment yourself during training? Yes/No

48. What teaching materials were used to train you?

1. None ☐
2. Dummy with foetal doll ☐
3. Charts and pictorials ☐
4. Models ☐
5. Any other (specify) _____

49. On completion of your training was any oral test given to you? Yes/No

If yes, what was enquired from you

1. _____
2. _____
3. _____

50. Did you give practical demonstration test? Yes/No

If yes, what you were asked to demonstrate?

1. _____
2. _____

51. Do you feel any need for further training? Yes/No

If Yes, for how long? _____ Days

and on what aspects?

1. _____
2. _____
3. _____

52. How much stipend did you receive for training? Rs._____

When was it paid to you?

1. Immediately after training ☐
2. Within a month ☐
3. After a month ☐
4. After 3 months or more ☐

53. Do you get any money for registering the cases with the A.N.M. Yes/No

If Yes, how much per case?

1. Antenatal Rs._____
2. Postnatal Rs._____

54. What problems did you face during training?

1. _____
2. _____
3. _____

55. Are you facing any of the following problems in working as Dai?

1. Replenishment of Maternity Kit Yes/No
2. Cooperation/guidance from H.W.(F)/A.N.M. Yes/No
3. Cooperation from and acceptance in the Community Yes/No
4. Professional Jealousy of untrained Dai of your area Yes/No

56. Do you think that your training has helped you to work better as Dai? Yes/No

Give reasons:

_____

_____

57. What suggestions would you like to make to improve the training of Dais?

_____

_____

_____

58. Interviewer's comments:

_____

INDIAN INSTITUTE OF MANAGEMENT, BANGALORE DEQ - 2

In Collaboration With

NATIONAL INSTITUTE OF HEALTH & FAMILY WELFARE

NEW DELHI

(Ministry of Health & Family Welfare, Government of India)

Evaluation of Dai Training Scheme, 1980

Interview Schedule for HW(F)/ANM/Trainer

Schedule No. [ ][ ][ ][ ]

State _____

District _____

P.H.C. _____

Sub-Centre _____

Pop. of Sub-centre _____

1. Name of Respondent _____

2. Designation: _____

3. Marital Status: U / M / D / W

4. Educational Status: Middle / H.S. / H.Sec. / Inter / Graduate

5. Total experience _____ Middle _____ Year _____

6. Do you have experience of training the Dais? Yes/No

6. (A) If Yes, how mary batches you have trained so far? i. _____ Nos. ii. Total No. of Dai trained _____ Nos.

6. (B) Did you undertake the training of dais at this sub centre? Yes/No

7. Do you have a list of all the Dais of your area. Yes/No

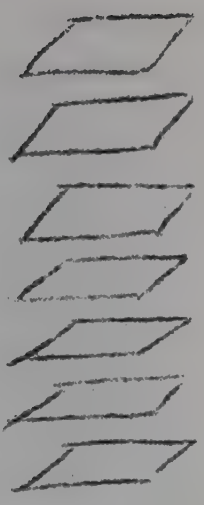
(If yes, obtain a copy of the list)

8. What considerations you have while recommending/selecting Dais for training?

1. Belongs to the village which has no Dai. [ ]

2. Belongs to remote area. [ ]

3. Interested in improving dais work
4. Competent and popular dai of area.
5. Supported by pressure groups.
6. Suggested by Health authorities.
7. Personal attachement.
8. Needy woman of the area.
9. Any other (specify)



9. Are the untrained dais of your area willing to undergo training? Yes/No

If No, give reason.

10. Tick against the following facilities which are available at Sub-Centre.

Facilities	Availability
1. Black Board	Yes/No
2. Chalk	Yes/No
3. Dai kit for demonstration	Yes/No
4. Dummy and foetal doll	Yes/No
5. Models	Yes/No
6. Charts	Yes/No
7. Stove in working order	Yes/No
8. Kerosin Oil as per need of the training	Yes/No
9. Utensils for boiling/kit equipments	Yes/No
10. Test tubes	Yes/No.
11. Reagents to test	
1. Albumin	Yes/No.
2. Sugar	Yes/No
12. Spirit Lamp	Yes/No.
13. B.P.Apparatus with stethescope	Yes/No
14. Thermometer	Yes/No
15. Anema	Yes/No
16. Weighing Machines	Yes/No
17. Facilities for Hb estimation	Yes/No

11. Do you find any language difficulty in explaining and talking to Dais? Yes/No

    If Yes, describe the nature of difficulty.

    1.

    2.

    3.

12. Do you find any short comings in the mid-wifery practices of Dais? Yes/No

    If yes, what are these?

    1.

    2.

    3.

    4.

13. Would/Did you like to function as a trainer? Yes/No

    If no, state reasons?

    1.

    2.

    3.

    4.

14. Did you conduct follow up of trained dais? Yes/No

    If yes, what improvements in Mid-wifery practices of dais you observed

    1.

    2.

    3.

    4.

    5.

15. What specific guidance you provided to trained dais during follow up visits?

    _____

    _____

    _____

16. Do you send reports about:-

1. Progress of training Yes/No

2. Follow up trained dais Yes/No

17. What type of cocperation. you are getting from Dais who are:

A. Trained _____

_____

_____

_____

_____

B. Untrained _____

_____

_____

_____

_____

18. Do you get any support of guidance from your supervisors & P.H.C. staff. Yes/No

If yes, what type of guidance or support.

_____

_____

_____

_____

Note:- Question from T-1 to T-17 to be asked only from those who are/were were trainers.

T-1. What additional arrangements you made to conduct the Dai training at you sub-centre?

1. _____

2. _____

3. _____

4. _____

T- What major functions you expect a Dai to undertake after training?

1. _____

2. _____

3. _____

4. _____

T-3 A. Did you get the copy of the guidance and suggested schedule of training for Dais? ... Yes/No

B. If Yes, in what form those were provided to you.

1.

1. _____

2. _____

3. _____

C. If no, how many days and hours you are devoting for the following.

	No. of Days	No. of Hours
1. Class room activities		
2. Class/Clinic activities		
3. Field activities		
A. Supervised		
B. Unsupervised		

T-4 During training which of the add beliefs and practices of Dais you came to know regarding the following:-

A. Ante-natal mother's food habits, mobility, rest etc.

1.

2.

3.

4.

B. Place and practices of managing labour room, ventilation, bed, drags etc.

1.

2.

3.

C. Management of new born (Cutting and care of Cord, feeding, bathing, medicines etc.)

1.

2.

3.

4.

D. Immunization of mother and baby.

1.

2.

3.

E. Family Planning Practices.

1.

2.

3.

F. Prophylaxis against nutritional anaemia.

1.

2.

3.

T-5. In order to improve Dais practices what demonstrations you gave during training to focuesabout

1. Aseptic measures.

1.

2.

3.

4.

2. General Health Checkup for mother children.

1.
2.
3.
4.

3. Immunization.

1.
2.
3.
4.

4. Management of labour.

1.
2.
3-
4.

5. Preparation for Home Confinement.

1.
2.
3.
4.

6. Family Planning methods.

1.
2.
3.
4.

T-6 Which of the following teaching methods were used by you during the training of Dais?

1. Lecture Yes/No
2. Lecture Cum discussion Yes/No
3. Demonstration and discussion Yes/No
4. Return demonstration & discussion Yes/No
5. Group discussion Yes/No

6. Rob play — Yes/No

7. Observational visits. — Yes/No

8. Case demonstration — Yes/No

T-7 Which of the above teaching methods were used to teach about the following family planning methods to Dais during training.

(Indicate the number of teaching methods given in question T-6. against each of the following)

1. Nirodh
2. Foam tablets
3. Jelly
4. Oral Pills
5. I.U.D.S.
6. Sterilization
7. M.T.P.

T-8. Indicate the conditions under which you instructed the trainee dais to refer the mother and children unfailingly to sub centre /P.H.C.

	Conditions for referral				
	1	2	3	4	5
Mother					
Child					

T-9 Did you prepare lesson plan for dai training?

If Yes, on what topics.

If no, give reasons

_____

_____

_____

T-10. How do you ensure that the dais under training require right skill and under-standing?

1.

2.

3.

4.

T-11. When you observe that a particular Dai under training is unable to learn as required, how do you help her to imrpove?

1.

2.

3.

4.

T-12. Did you conduct any final Evaluation of Dais after completion of training? Yes/No

If yes, what was the content of Evaluation.

1. _____

2. _____

3. _____

4. _____

T-13. What problems you faced in conducting the training of Dais.

1. _____

2. _____

3. _____

4. _____

T-14. To what extant did you consider the training programme conducted by you for Dais was:-

	Response	Reason for the response
1. Highly satisfactory		
2. Satisfactory		
3. Least Satisfactory		

T-15 Do you feel that the "One Month" training provided to dais is adequate for her functioning.

If no, what suggestion would you like to make in the training of dai togarding:-

1. Selection Criterian _____
2. Contents of training _____
3. Duration of training _____
4. Methods & Techniques of training _____
5. Methods of Evaluation _____
6. Teaching material _____
7. Competence of trainer _____
8. Incentive for trainee _____

T-16 Do you feel any need for retraining of already trained Dais? If yes after how many years? Yes/No

Where _____

In what subjects/areas? _____

..or how long? _____

T-27 Did you conduct any retraining programme? Yes/No

DEQ - 3

INDIAN INSTITUTE OF MANAGEMENT, BANGALORE

in Collaboration with

NATIONAL INSTITUTE OF HEALTH & FAMILY WELFARE,

NEW DELHI

(Ministry of Health & Family Welfare, Govt. of India)

Evaluation of Dai Training Scheme - 1980.

Schedule No. ☐☐☐

State:

District:

PHC/Sub Centre:

Trainer:

Designation:

P A R T - I

Class room observation Schedule:

1. Topic of the lesson

2. Duration of the lesson

3. Place of Training:

   1. PHC ☐
   2. Sub Centre ☐
   3. Any other (Specify)) ☐

4. Class held in:

   1. Room ☐
   2. Verandah ☐
   3. Open ☐

5. Seating arrangements:

	For teacher		For trainers	
	Yes	No	Yes	No
1. Dari				
22. Floor				
3. Chairs				
4. Any Other				

6. Availability of Black Board and Chalk — Yes/No

   If Yes, is it used for Sketching only — Yes/No

7. Lesson plan prepared: — Yes/No

8. Language used while teaching

   (a) Local dialect. ☐

   (b) Simple mother-tongue/Hindi ☐

   (c) Technical terms in English ☐

   (d) English terms used but defined in mother tongue ☐

9. To communicate in local language trainer finds. — Easy/Diificult

10. Teaching methods/techniques being used:

   (a) Talk by trainer ☐

   (b) Conversation with trainees. ☐

   (c) Demonstration and discussion. ☐

   (d) Return demonstration. ☐

   (e) Group discussion ☐

   (f) Question answer ☐

   (g) Any other (specify) _____ ☐

11. Teaching aids used during the lesson:

   1. Dummy with foctal doll ☐

   2. Charts ☐

   3. Models ☐

   4. Maternity Kit ☐

12. Handling of teaching aids:

   1. Exposes when required ☐

   2. Remains exposed throughout the class period. ☐

13. Does trainer ask questions related to mothers shown to dai in the fields? Yes/No

14. Opportunity to trainees for discussion among themselves:

    1. Sufficient
    2. Some what
    3. Not at all

15. Trainer attempts to know whether trainees have understood by making them:

    1. To give summary/resume
    2. Ask quizzes
    3. Encourage to raise doubts for clarrifications.
    4. Encourage trainees to ask among themselves.

16. Trainer handles the questions of trainees by:

    (a) Responding herself
    (b) Asking other trainees to respond
    (c) Discouraging the trainees to ask questions.
    (d) Rephrasing the question if there is norosponse from trainees.

17. Trainer gives demonstration: Yes/No

    If Yes. 1. By herself.
    2. Involves trainees in the process

18. Return demonstration by trainees: Yes/No

    If trainer detects any mistake in the demonstration he:

    1. does not correct
    2. corrects immediately
    3. Asks other trainees to correct
    4. Tells about the mistakes at the end of demonsttation.

19. Trainer asks question only:

    1. At the end of lesson
    2. In between
    3. In the beginning only
    4. Never

20. While talking to the trainer trainees feel:

    1. Very free
    2. Free
    3. Hesistant

21. Trainer tries to:

    1. Feed information to class
    2. Share experiences and modify them
    3. Seek information but does not use in the lesson.

22. The relation of trainer with trainees in:

    1. Cordial
    2. Indifferent
    3. Tense

23. Do trainees ask for more information from the Trainer Yes/No

P A R T - II

(A) Observation schedule for the clinic/Home during field Training

Pre - natal Care	Performance of Activities by HW(F)/ANM	HW(F)/ANM to dai bbout the activities
1. Name of the mother recorded by HW(F)/ANM	Yes/No	Yes/No
2. Physical examination:		
(a) Height of uterus	Yes/No	Yes/No
(b) Postition of foetus	Yes/No	Yes/No
(c) Foetus heartsound	Yes/No	Yes/No
(d) Oedema of feet	Yes/No	Yes/No
3. Laboratory examination		
(a) Urine - Albumin	Yes/No	Yes/No
- Sugar	Yes/No	Yes/No
(b) Blood for Hb.	Yes/No	Yes/No
4. Blood Pressure measured	Yes/No	Yes/No
5. Weight recorded	Yes/No	Yes/No
6. Prophylaxis against nutritional anaemia given.	Yes/No	Yes/No
7. Family planning advice given	Yes/No	Yes/No
8. Immunization (T.T.)	Yes/No	Yes/No
9. Nutrition education	Yes/No	Yes/No
10. Education for personal hygiene	Yes/No	Yes/No

(B) Natal Care (Home Delivery)	Actual performance by		HW(F)/ANM explains about the activity to dai
	HW(F)/ANM	Dai	
1. Checks the room for delivery and other requirements.	Yes/No	Yes/No	Yes/No
2. Comforts the mother	Yes/No	Yes/No	Yes/No
3. Washes her hands with Soap			

Natal care (Home Delivery)	Actual performance by		HW(F)/ANM explains about the activity to Dai.
	HW(F)/ANM	Dai	
4. Arranges and boils the scissors and cord ligtures.	Yes/No	Yes/No	Yes/No
5. Examines mother and watches the progress of labour	Yes/No	Yes/No	Yes/No
6. Properly supports the perineum (to avoid tear)	Yes/No	Yes/No	Yes/No
7. Separatos the baby after tieing and cutting the cord.	Yes/No	Yes/No	Yes/No
8. Gives sufficient time for separation and explosion of placentra.	Yes/No	Yes/No	Yes/No
9. Cleans and puts the mother in comfortable position.	Yes/No	Yes/No	Yes/No
10. Asks for drinks and gives to mother.	Yes/No	Yes/No	Yes/No
11. Checks the cord for bleeding and cleans it.	Yes/No	Yes/No	Yes/No
12. Gives immediate care to new born baby.	Yes/No	Yes/No	Yes/No
13. Proper disposal of placenta and other waste material.	Yes/No	Yes/No	Yes/No
14. Instructs regarding feeding of mother and baby.	Yes/No	Yes/No	Yes/No
15. Informs regarding time of revisit by her or dai	Yes/No	Yes/No	Yes/No

(C)

Post-natal Care	Actual performance by		HW(F)/ANM explains about the activity to Dai.
	HW(F)/ANM	DAI	
1. Baby bath	Yes/No	Yes/No	Yes/No
2. Care of cord	Yes/No	Yes/No	Yes/No
3. Perineal care (wash down and clean pad)	Yes/No	Yes/No	Yes/No
4. Check about the	Yes/No	Yes/No	Yes/No
1. Mother	Yes/No	Yes/No	Yes/No
2. Baby	Yes/No	Yes/No	Yes/No
5. Identifies any complication with	Yes/No	Yes/No	Yes/No
1. Mother	Yes/No	Yes/No	Yes/No
2. Child	Yes/No	Yes/No	Yes/No
6. Adiice for referral	Yes/No	Yes/No	Yes/No
7. Advice for child immunization	Yes/No	Yes/No	Yes/No
8. Advice for family planning	Yes/No	Yes/No	Yes/No
9. Introduced the dai to family planning depot holders.	Yes/No	Yes/No	Yes/No

INDIAN INSTITUTE OF MANAGEMENT, Bangalore
in Collaboration with
NATIONAL INSTITUTE OF HEALTH AND FAMILY WELFARE
NEW DELHI
(MINISTRY OF HEALTH AND FAMILY WELFARE, GOVT. OF INDIA)

EVALUATION OF DAI TRAINING SCHEME 1980

INTERVIEW SCHEDULE FOR MOTHER DELIVERED BY DAI

Schedule No. [ ][ ][ ][ ]

State _____

District _____

P.H.C. _____

Sub-centre _____

Village _____

Type of Village

1. P.H.C. Village [ ]
2. Sub-centre village [ ]
3. Other, 5 km remote village [ ]

Name of Dai who identified the mother _____

Training status of Dai: 1. Trained [ ]
2. Untrained [ ]

If trained, when? _____ month _____ Year

---

1. Name of the mother _____
2. Age _____ Years
3. Income of your family (monthly) _____ (as stated)
4. Total number of deliveries _____ Nos.
5. Since how long you know this Dai? _____ Years
6. Was this Dai usually available when you needed her Yes/No

7. How many of your children were delivered by this Dai? _____ Nos.

8. When was the last delivery conducted by this Dai?

For trained Dai:

Before Training ☐

After Training ☐

For untrained Dai

Before 1973 ☐

After 1973 ☐

9. Details of deliveriss conducted by the above Dai in the family: (Begin with the last deliver)

Details	Last Child	Any Earlier Child
Sex: 1. Male 2. Female	☐ ☐	☐ ☐
Year of Birth		
Status of Baby: 1. Living 2. Dead	— ☐ ☐	☐ ☐
If Dead 1. Age at death 2. Cause of death		
Amount of payment to Dai 1. Cash 2. Kind		

	Last Child	Any Earlier Child
10. Did Dai get you registered at the Sub-centre?		
Yes		
No		
If Yes, at what time of pregnancy:		
3 months.....		
5 months.....		
7 months.....		
9 months.....		
11. Did Dai bring HV(F)/ANM to you at your home during your pregnancy?		
Yes		
No		
12. Did you ever visit the clinic during your pregnancy at sub-centre or PHC		
Yes		
No		
If Yes, what was the purpose of visit? (Answers are not to be read out?		
1. Regular check up		
2. Immunization (Mother)		
3. For related complaints		
4. To collect Iron with Folic Acid		
13. Had Dai advised you for?		
1. Tetanus Toxoid Yes		
No		
2. Prophylaxis against nutritional anaemia Yes		
No		

13. (continued)

		Last Child	Any Earlier Child
3. Preparation for home confinement	Yes		
	No		
4. Regular check up	Hes		
	No		
14. Did you attend the clinic to receive:			
A. Tetanus Toxoid:			
1. One dose			
2. Two doses			
3. Three doses			
B. Iron with Folic Acid:			
1. 15 Tabs			
2. 30 Tabs			
3. 60 Tabs			
4. 90 - 100 Tabs			
15. Which of the following problems you faced during the pregnancy?			
1. Swelling of feet			
2. Bleeding			
3. Repeated attach of pain			
16. In case of the above problems to whom did you contact first?			
1. Dai			
2. HV(F)/A.N.M.			
3. HA(F)/L.H.V.			

16. (continued)

	Last Child	Any Earlier Child

4. P.H.C.

5. Private practitioner

(Ask if the First contact was Dai only)

What did Dai do for you?

1. Treated me

2. Called HW(F)/ANM for visit

3. Took me to sub-centre

4. Refered me to P.H.C.

5. Advised to consult any practitioner

(THE FOLLOWING QUESTIONS CAN ALSO BE ASKED FROM THE ELDERLY LADY IN THE FAMILY IF MOTHER FAILS TO RESPOND?

17. How many hours before was Dai present at your place to conduct delivery?

1. More than on hour before

2. 1/2 hour before

3. Just before the birth of Child

4. After the birth of Child

18. Did Dai came along with any Lady Health Worker?

Yes

No

If Yes, who accompanied her:

1. H.W.(F)/A.N.M.

2. H.A.(F)/L.H.V.

19. Did Dai bring maternity kit alongwith her? Yes

Nc

	Last Child	Any Earlier Child

20. On arrival did Dai do the following:

1. Wash her hands with Soap and Water	Yes	
	No	
2. Boil the equipment required for	Yes	
	No	
3. Give drinks during labour	Yes	
	No	
4. Comfort the mother	Yes	
	No	
5. Press mother abdomen hard	Yes	
	No	
6. Administer any drug	Yes	
	No	

21. With what did Dai cut the cord?

1. Scissors
2. Blade
3. Any other (Specify)_____

22. Was the above equipment boiled by Dai in your home to cut the cord? Yes / No

23. Did you keep old clothes washed and ready for use as sanitary pads? Yes / No

24. Did Dai use rubber sheet during delivery? Yes / No

	Last Child	Any Earlier Child
25. How much total time did Dai spent with you during delivery (in hours)		
26. Did you suffer with any of the following complications after deliver?		
1. Fever		
2. P.P.H.		
3. Any other (Specify)		
27. Did you report about the above complication to DAI?		
Yes		
No		
If Yes, what action was taken by Dai:		
1. No action		
2. Gave drugs herself		
3. Suggested indigenous drugs		
4. Called HW(F)/ANM to visit		
5. Referred to P.H.C.		
6. Any other (Specify)		
28. Did your baby develop any complication within first fortnight after birth?		
Yes		
No		
If Yes, what complication the baby had:		
1		

	Last Child	Any Earlier Child

29. In case of these complications mentioned above what line of action was taken by Dai to help your child:

    1. Refered to HW(F)/ANM
    2. Refers to P.H.C.
    3. Advice to consult private practitioner
    4. Suggested indigenous drugs
    5. Administers drugs herself
    6. Did nothing

30. Regarding which of the following Dai had given you advise?

    1. Personal Hygiene
    2. Feeding the baby
    3. Care of cord
    4. Immunisation of baby
    5. Family Planning

31. In what other matters of Health did you seek Dai's advice/ help beside deliveries?

    1. _____
    2. _____
    3. _____

32. Are you satisfied with the services of Dai who attended on you?

    Yes

    No

    Give reasons:

    1. _____
    2. _____
    3. _____

33. Interviewer's comments (if any)

    1. _____
    2. _____
    3. _____

DEQ - 5

INDIAN INSTITUTE OF MANAGEMENT, BANGALORE
in COLLABORATION with
National Institute of Health & Family Welfare,
New Delhi
(Ministry of Health & Family Welfate, Govt. of India)

Evaluation of Dai Training Scheme, 1930

Interview Scehdule for District Level Officers

Part I Scehdule No. /////

State _____

District _____

1. No. of PHC in the district: _____

2. Target and achievement related to training of Dais in the District.

S.No.	Year	Target	Achievement	Kits Received	Kits issued	Remarks
1.	1978-79					
2.	1979-80					
3.	1980-81					

(Up to the date of data collection)

3. No. of PHCs where Dais training has been completed (Since 1978 to date of data collection) _____

Name of four such P.H.C.'s (Select randomly from the list)
1. _____
2. _____
3. _____
4. _____

4. No. of PHCs where Dai training is going on at present. _____

Name of two such P.H.C's.
(select randomly from the list)
1. _____
2. _____

(Part II)

To be used for interviewing both District Medical & Health Officer/Chief Medical Officer and District P.H.N.

1. Name of the District M.O./District P.H.N. _____

2. What are your specific responsibilities related to Dai training scheme.

   1.

   2.

   3.

   4.

3. How do you feel about the Dai training as it is being implemented in your District?

   Highly satisfied ☐

   Some what satisfied ☐

   Not satisfied ☐

3.a. Please give reasons for it.

4. Did you prepare a plan of implementation for Dai training in your District? Yes/No.

   '(If yes, please obtain a copy of the plan)

5. How is the Dai training being supervised in your district?

   1.

   2.

   3.

   4.

6. Are you facing problems related to following aspects of Dai Training Programme?

	Yes	No	If Yes, state the problem
1. In the payment of stipend after the completion of training.			
2. Distribution of maternity kits to trained Dais.			
3. Replenishment of maternity kits to trained Dais			

(6) Continued

	Yex	No	If Yes, state the problem
4. Supply of sterlization equipment for demonstration to Dai Training Centre.			
5. Provision of A.V.Aids (Charts, atlas etc.)			
7. Supply of Dummy, (Obstetrical mannikin) foetal doll and other models.			
8. Getting monthly progress and evaluation reports regarding Dai training from PHCs.			
9. In providing feedback to sub centres conducting Dai Training.			
10. Any other (Specify)			

7. How do you ensure from the M.O. PHC: that the Dais already trained are being followed for technical guidance by H.W.(F)/A.N.M.

8. Have you ever received any complaint regarding selection of Dais for training? Yes/No

If yes,

a. From whom:
- Community members
- Village leaders
- Political leaders of the area
- Any other (Specify)

(Answers not to be Read)

b. Nature of complaints

c. Action taken

9. Do you provide any badges/Certificates to trained Dais. Yes/No

10. Is there any system of Registration for Dais trained in your PHCs? Yes/No

10.A. If yes, with whom

a. State Nursing Council

b. State Bureau of M.C.H. and Family

c. Any other (Specify) _____

11. What are your suggestions for further improvement of Dai training?

_____

_____

_____

_____

12. Inter viewers comments _____
(If any) _____

_____

(PART II)

To be used for interviewing both District Medical & Health Officer/Chief Medical Officer and District P.H.N.

1. Name of the District M.O./District P.H.N. _____

2. What are your specific responsibilities related to Dai training scheme.

1.

2.

3.

4.

3. How do you feel about the Dai training as it is being implemented in your district?

Highly satisfied

Some what satisfied

Not satisfied

3a. Please give reasons for it

4. Did you prepare a plan of implementation for Dai in your District? Yes/No

(If yes, please obtain a copy of the plan)

5. How is the Dai training being supervised in your distict?

1.

2.

3.

4.

6. Are you facing problems related to following aspects of Dai Training Programme?

	Yes	No	If Yes, State the Problem
1. In the payment of stipend after the completion of training.			
2. Distribution of maternity kits to trained Dais.			
3. Replenishment of maternity kits to trained Dais.			
4. Supply of Sterlization equipment for demonstration to Dai Training Centre			
5. Provision of A.V.Aids (cnarts, atlas etc.)			
6. Supply of Dummy (Obstetrical mannikin) foetal doll and other models.			
7. Supply of seating arrangement for Dai Classes.			
8. Getting monthly progress and evaluation reports regarding Dai training from PHCs.			
9. In providing feedback to sub centres conducting Dai. Training.			
10. Any other (Specify)			

7. How do you ensure from the M.O. PHC that the Dais already trained are being followed for technical guidance by H.W.(F)/A.N.M.

8. Have you ever received any complaint regarding selection of Dais for training? Yes/No

If yes,

a. From whom? - Community members ☐
- Village leaders ☐
(Answers not to be Read) - Political leaders of the area
- Any other (Specify) _____
_____

b. Nature of complaints _____

c. Action taken _____
_____

9. Do you provide any badges/Certificates to trained Dais. Yes/No

10. Is there any system of Registration for Dais trained in your PHCs? Yes/No

10A. If Yes, with whom.

a. State Nursing Council ☐
b. State Bureau of M.C.H. and Family Planning ☐
c. Any other (Specify) _____

11. What are your suggestions for further improvement of Dai training?

a _____
_____
_____
_____

12. Interviewers Comments _____

(If any) _____
_____

INDIAN INSTITUTE OF MANAGEMENT, BANGALORE

in collaboration with the

NATIONAL INSTITUTE OF HEALTH & FAMILY WELFARE, NEW DELHI

(Ministry of Health and Family Welfare, Govt. of India)

Evaluation of Dai Training Scheme - 1980

Interview Schedule for M.O. Incharge, P.H.C.,

Schedule No. _____

State _____

District _____

P.H.C. _____

1. Name :
2. No. of sub-centres in the P.H.C. :
3. No. of HAs(F)/LHVs in position :
4. Population of P.H.C.
5. Do you have a villagewise list of all Traditional Dais of your P.H.C. indicating their training status and year of Training? — Yes / No

   If yes, obtain a list.

5(A). Give the number of Dais under each category as below since April 1978

Since when?

	1978-79	1979-80	1980-81
1. Trained			
2. Untrained			
3. Under training			

6. How many villages in your P.H.C. are without any Dai? _____Nos.

7. Data for training of Dais:

Year	Target	Achievement	No. of Kits issued to Dais	No. of Kits replenished
1980-81				
1979-80				
1978-79				

8. Where is the training organized in your P.H.C. ?

1. At the P.H.C. H.Q. ☐
2. In all the Sub-centres ☐
3. At selected Sub-centres ☐
4. At P.H.C. H.Q. and Sub-centres ☐

8(A). If the answer in Q.(8) is (2,3,4) please ask 'how do you manage the supply of teaching aids for the training of Dais at various Sub-centres?'

_____

_____

_____

_____

_____

9. Who actually conducts the training programme for Dais?

1. H.A.(F)/L.H.V. ☐
2. H.W.(F)/A.N.M. ☐
3. H.A.(F)/L.H.V. and H.W.(F)/A.N.M. ☐
4. Any other (specify) .....

10. How do you supervise the progress of Dai's training in your P.H.C.?

11. On whose advice you generally select Dai for training?

12. Which of the criteria you adopt for the selection of Dai for training?

1. Age ☐
2. Caste ☐
3. Experience ☐
4. Competence of Dai ☐
5. Popularity ☐
6. Economic Backwardness ☐
7. Belonging to the remote village ☐
8. Belongs to village which has no Dai ☐
9. Any other (Specify) .....

13. Had there been any representation against you or your staff regarding selection of Dai for training?

If yes, please narrate:

14. Do you face ANY OF THE FOLLOWING PROBLEMS regarding Dai training?

	Yes	No	If yes, specify the problem
1. Seating arrangements	☐	☐	_____
2. Provision of A.V. Aids	☐	☐	_____
3. Dummy (Obstetrical Mannikin), foetal doll and other models for training at Sub-centre	☐	☐	_____
4. Supply of Sterilization equipments at the Sub-centre for training	☐	☐	_____
5. Distribution of maternity kits during training	☐	☐	_____
6. Replenishment of distributed maternity Kits	☐	☐	_____
7. Making payments of stipend immediately after the completion of training	☐	☐	_____
8. Getting monthly progress report and evaluation report regarding Dai training from Sub-centres.	☐	☐	_____
9. Any other (specify)			_____

15. Please give your views regarding:

1. Curriculum for Dai training

2. Duration of Dai training

16. How do you feel about the training of Dais as it is being implemented in your P.H.C.?

Highly satisfied ☐

Some what satisfied ☐

Not satisfied ☐

16 (A) Please give reasons in support of your answer.

17. Are the trained dais of your P.H.C. being followed up and provided technical guidance by?

1. H.W.(F)/A.N.M. Yes / No

2. H.S.(F)/L.H.V. Yes / No

17(A). If yes, do you receive regularly from the H.W.(F)/A.N.M. or H.A.(F)/L.H.V. ?

1. Programme for follow up of Trained Dais Yes / No

2. Follow up Report of Trained Dais Yes / No

18. What procedures do you use to evaluate the functioning of Trained Dais?

19. Interviewers comments (if any)

_____

_____

_____

_____

_____